Supreme Court, U.S.
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No. _____

IN THE SUPREME COURT OF THE UNITED STATES

CRYSTAL STAR PHILLIPS, individually, and As next of kin to Martin Shane Phillips, on behalf of THE ESTATE OF MARTIN SHANE PHILLIPS By and through her mother, legal guardian and Next friend, MINNIE CHRISTINA DACZEWITZ, and FRED MARTIN PHILLIPS JR., parent of Martin Shane Phillips,

the Petitioners,

vs.

HILLCREST MEDICAL CENTER, an Oklahoma corporation doing business in the State of Oklahoma,

the Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. Whether separation of powers was violated by the Tenth Circuit when it re-legislated Congress' intent clearly expressed in 42 U.S.C. § 1395dd(a) of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), by preempting that expressed intent with its newly articulated holding that hospital violations of § 1395dd(a) are measured by a "perceived" standard, which in fulfilling a hospital's EMTALA obligation, only requires hospital personnel to "perceive" an illness or not "perceive" an illness, and eliminates the medical screening examination requirement of subsection (a), as defined by Congress in subsection (e)(1)?

II. Whether separation of powers was violated by the Tenth Circuit when it contravened the Legislature's intent, by creating a safe harbor for "patient dumping", an intentional act, conceded by the Tenth Circuit to be the very "evil" Congress intended to cure, but nonetheless, even in the presence of serious and voluminous evidence that hospital personnel did in fact perceive the patient's true condition and further chose to circumvent EMTALA's requirements by misrepresenting the patient's true condition in the medical chart, and by testifying they "did not perceive" the condition at issue, held notwithstanding this evidence, that a hospital will not be liable for an EMTALA violation under § 1395dd(a), as long the hospital personnel testify that they "did not perceive" symptoms in a particular patient?

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PETITION FOR WRIT OF CERTIORARI

Petitioners' respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Tenth Circuit in this case.

OPINIONS AND ORDERS BELOW

The district court's consideration and order (per Holmes, D.J.) granting Respondent, Hillcrest Medical Center's ("Hillcrest") Rule 50 motion as to Petitioners' cause under the Emergency Medical Treatment and Active Labor Act, at the close of Petitioners' case-in-chief, is not published, and is reprinted in the Appendix. *App.* p. 21-49. The court of appeals opinion (per Belot, D.J., joined by Seymour and McWilliams, JJ.) is published at *Phillips v. Hillcrest*, 244 F.3d 790 (C.A.10 2001), and is reprinted in the Appendix. *App.* p. 1. The court of appeals order granting Petitioners' motion to file corrected petition for panel rehearing is reproduced in the Appendix. *App. p. 50-51.* The court of appeals' order denying rehearing is reprinted in the Appendix. *App.* p. 52-53.

STATEMENT OF JURISDICTION

The United States Court of Appeals in and for the Tenth Circuit entered its opinion and order on March 26, 2001, and denied panel rehearing on May 9, 2001. Justice Breyer subsequently extended the time to file this petition for a writ of certiorari to and including October 6, 2001. Petitioners invoke this Court's jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL PROVISIONS AND STATUTORY PROVISIONS INVOLVED

The provisions of the United States Constitution, Articles I, II, and III, relevant to this petition are reprinted in the Appendix at p. 80. The Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, *et seq.*, that is relevant to this petition is reprinted in the Appendix at p. 54. Also, pertinent is U.S.C. §

1395x, specifically (r)(1) is reproduced in the Appendix at p. 64. General provision for civil monetary penalties, 42 U.S.C. § 1320a-7a, is reproduced in the Appendix at p. 65.

STATEMENT OF THE CASE

On September 28th 1998, roughly 4.5 days after Martin Shane Phillips was discharged from Hillcrest after being instructed by Hillcrest to make an appointment at a clinic for those without insurance or financial ability to pay, Martin Shane Phillips died while attempting to secure an appointment elsewhere. *App.* p. 267, ln 13- p. 268, ln 10; p. 227, ln 7-18; *Supp. App.* p. 20. Martin Shane Phillips died of a septic blood infection, also infecting his heart, agreed by the expert for the on duty physician, to have been proliferating at the time of Mr. Phillips' presentation to Hillcrest. *App.* p. 262, ln 7-13; p. 265, ln 3-18. The disposition record of the emergency room log has a ("?") question mark in the space for how this patient was diagnosed. *App.* p. 219, ln 8-14; *See Supp. App.* p. 23.

Petitioners' brought suit in the Northern District of Oklahoma under 42 U.S.C. § 1395dd, *et seq.*, the Emergency Medical Treatment and Active Labor Act, ("EMTALA"), against Hillcrest under the following: subsection (a) for failure "to provide an appropriate medical screening"; subsection (b) for failure to stabilize Mr. Phillips under (b)(1)(A); and again under subsection (b) because when Hillcrest transferred Mr. Phillips as defined by (e)(4), it failed to do so under (b)(1)(B), which requires all transfers to another medical facility to be in accordance with subsection (c) of § 1395dd.

Under (b)(1)(A), Petitioner's theory was that Hillcrest did not provide "within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition". *See* 42 U.S.C. § 1395dd(b)(1)(A). Petitioners contended that Hillcrest should have admitted Mr. Phillips to its hospital, where after "further medical examination", he would have been

treated for an underlying blood infection and still be alive today. *App.* p. 238, ln 6-15; *App.* p. 239 ln 2-16.

Under (b)(1)(B), Petitioner's theory was that upon discharging Mr. Phillips from its hospital, (which is defined as a transfer under (e)(4)), Hillcrest did not transfer Mr. Phillips "in accordance with subsection (c)". *See* 42 U.S.C. § 1395dd(b)(1)(B). In the absence of a written request by Mr. Phillips to be transferred, or in this case, "discharge[d]" to another hospital, subsection (c) requires prior to any transfer, that a signed certificate of evaluation by a physician or qualified medical personnel, concluding that the risks of transfer to another facility are reasonably expected to be outweighed by the benefits to be received at another medical facility. *See* 42 U.S.C. § 1395dd(b)(1)(B) and (c) *et seq*. Subsection (c) additionally required Hillcrest, prior to Mr. Phillips' "discharge" (i.e., transfer), to render medical treatment within its capacity, which would "minimize[sic]" the risk to Mr. Phillips' health during transfer; and, to further learn whether the OU Family Practice Clinic consented to this transfer, and whether it had "available space and qualified personnel" to treat Mr. Phillips, as well as provide that clinic with his treatment record *Id. at (c)(2), et seq.* No signed certificate pursuant to the requirements of subsection (c) *et seq*., was issued for Mr. Phillips, and neither was inquiry made for availability of space and qualified personnel to treat Mr. Phillips, nor did Hillcrest minimize health risks during this transfer, or arrange for Mr. Phillips' medical records to be conveyed to the OU Family Practice Clinic. *See Complete Chart, Supp. App.* p. 2- p. 20.

The district court granted Hillcrest's Rule 50 motion at the close of Petitioners' evidence, holding that § 1395dd(a) is only concerned with whether hospital personnel testified they "undertook"[1] to determine a patient's medical condition. *App.*

[1] The trial court never gave Petitioners a fair opportunity to be fully heard on the EMTALA violations, and therefore never entertained the scope of Petitioners' claims that Hillcrest failed to provide an "appropriate medical screening" violating § 1395dd(a) *et seq*., and also intentionally violated EMTALA and attempted to mask its violation by misrepresenting Mr.

p. 21- p. 49. Petitioners brought their appeal to the Tenth Circuit under 42 U.S.C. § 1395dd, *et seq.*, but specifically called attention to § 1395dd(a) because subsection (a) seems to be the conduit from which most every claim will flow, and the hinge on which most every claim is based. *See* 42 U.S.C.§ 1395dd, *et seq.* The Tenth Circuit has now held that EMTALA violations are measured by whether a hospital "treats every patient 'perceived' to have the same medical condition in the same manner". *Phillips v. Hillcrest,* 244 F.3d 790, 797 (C.A.10 2001), (emphasis added). This holding means that Hillcrest and all other hospitals in a circuit which follow this rule, may now intentionally violate EMTALA by hiding behind false testimony that hospital personnel did not "perceive" a particular patient's condition, and thereby creates a safe harbor for conduct,

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Phillips' condition, and upon learning of Mr. Phillips' death, changed the records to more readily line up with an EMTALA compliance. Upon inviting Petitioners' to explain their points, the trial court would rapidly veer off with its own agenda by requiring response to one of its questions, or cutoff the Petitioners. *App. p. 34, ln 24- p. 35, ln 3; p. 40, ln 3-8.* The following is typical of the entire exchange during the Rule 50 hearing: *Mr. Copeland:* "May I answer this question after I explain what the plaintiffs' theory of the case is?" *The Court*: "Well, your in a Rule 50 motion. The question is . . ." [infinitum]. *App. p. 44, ln 5- et seq.* And again, *The Court*: "Well, I'm focusing on whether or not there was any indication anywhere at the time of the treatment that there was some problem presented by insurance." *Mr. Copeland*: "Obviously there was, Your Honor, if we can look at the case as a whole and not isolate one particular area." *The Court*: "Isolate? You have somebody who is an eyewitness to a murder you want to look at the case as a whole but don't talk to the eyewitness. I like to stay with the eyewitness." *App. p. 36, ln 15-24.* The trial court maintained this attitude, disallowing inferences to be drawn for Petitioners' intentional theory of violation of § 1395dd(a), from anyone or anything other than Petitioners' witness, Mr. Lulka, who was present at Hillcrest during Mr. Phillips visit. *Id. See also App. p. 43, ln 10 – p. 49, ln 8.* This attitude endured even after having been told emphatically by Petitioners' counsel, "Your Honor, there are other policies [to be presented] but that's alright[!]" *App. p. 49, ln 7.* Violation of hospital policies, is admitted by the Tenth Circuit to be the measuring tool or a determining event, for a finding of disparate treatment under EMTALA. *Phillips v. Hillcrest,* at 797. Appellants attempted to argue to the trial court, but were told to "amplify [your record] many pages over in Denver". *App. p. 49, ln 3.*

admitted by many courts in this land, including the Tenth Circuit, to be the very "evil" EMTALA was promulgated to reproach. *See Phillips,* 244 F.3d at 796 ("[I]ntended to cure the 'evil' of dumping patients who could not pay..."), *See also, Owens v. Nacogdoches County Hospital District,* 741 F.Supp. 1269,1271 (E.D. Texas 1990) ("[T]he very evil which *§ 1395dd* was designed to prevent."). This newly articulated standard also means, that even in situations where intentional violations are not alleged, to avoid EMTALA liability, requires only that hospital personnel say they did not "perceive" a patient's illness or symptoms, and eliminates Congress' requirement to provide an "appropriate medical screening" under § 1395dd(a). *See* 42 U.S.C. § 1395dd(a), and 1395dd(e)(1). *See Phillips* at 797. *See Vickers v. Nash Gen. Hosp. Inc.,* 78 F.3d 139, 144 (4th Cir. 1996), ("EMTALA is implicated only when individuals who are perceived to have the same medical condition receive disparate treatment..."). This holding re-legislates Congress's original intent to protect the public so drastically, it violates separation of powers. *U.S. Const. Art. I, § 1; Phillips* at 797.

On September 23rd, 1998 Martin Shane Phillips presented to Hillcrest Medical Center, with complaints of "tremendous" chest pain, and an abnormally fast heartbeat. *App.* p. 177, ln 11; *Supp. App.* p. 8. Mr. Phillips' presentation of chest pain and fast heartbeat, also known as tachycardia, are undisputed facts. *App.* p. 210, ln 18; p. 240, ln 4-16. What was in dispute was Mr. Phillips' clinical appearance when he presented to the medical personnel of Hillcrest. In addition to the undisputed facts of chest pain and tachycardia, Petitioners presented evidence at trial, by four independent witnesses, that Mr. Phillips, just prior to or at the time of his presentation to Hillcrest hospital, "looked like the walking dead"; that he was "ashen" and not "normal" looking; that he was "greenish"; looked "weak"; and that his lungs were "gargulatious" and sounded as though he had "walking pneumonia"; and he was slumped over in the emergency waiting room with tears in his eyes. *App.* p. 250, ln 22- p. 251, ln 3; p. 172, ln 10- p. 173, ln 19; p. 177, ln 9-11; p. 179, ln 14-24; p. 191, ln 25- p. 193, ln 24. None of these dramatic symptoms and clinical observations

appear in the medical chart prepared by Hillcrest personnel; but instead, the record is riddled with contradictions.

Dr. Cobb, the physician on duty in the emergency room during Mr. Phillips' presentation, dictated, "On examination, this is a well-developed, well-nourished, pleasant gentleman". "Examination is very unremarkable." *Supp. App.* p. 12. Dr. Cobb buttressed this at trial when she testified that during her examination, Mr. Phillips "didn't appear to be in any distress". *App.* p. 213, ln 4-5. However, Dr. Cobb forgets this testimony and later in the trial testifies, "Mr. Phillips was not feeling well. I mean that was obvious both to me and to him, and so for that reason I gave him several days off work for him to rest". *App.* p. 216, ln 14-16. This evidence showed that Dr. Cobb admitted that at the time of her examination of Mr. Phillips, he was weak and appeared ill, and that she was contradicting both her earlier testimony that Mr. Phillips "did not appear to be in any distress, *supra*, and her dictation that his "[e]xamination is very unremarkable". *Supp. App.* p. 12.

Four and one half days later, with less than four hours of life left in him, when Mr. Phillips presented to Tulsa Regional Medical Center, ("TRMC"), Hillcrest's sister hospital, there, Dr. Phillip Murta, a resident intern, began initially working Mr. Phillips up for pneumonia due to the fluid build-up in his lungs. *App.* p. 183, ln 11-20. At trial, witness Michael Dacewitz testified that when he saw Mr. Phillips within one hour prior to Mr. Phillips' Hillcrest emergency room visit, Mr. Phillips' lungs sounded "gargulatious" and reminded him of his mother's walking pneumonia. *App.* p. 179, ln 19- p. 180 ln 7; p. 178 ln 4-10. This is evidence of fluid in Mr. Phillips' lungs, both, just prior and just after Mr. Phillips' visit to Hillcrest; and moreover, was identified in the first instance by a lay witness, Mr. Dacezwitz whose testimony was corroborated by Dr. Murta's, *supra*. Yet, Dr. Cobb's medical dictation regarding Mr. Phillips' lungs states, "Lungs: Clear lungs to auscultation. No increased respiratory effort." *Supp. App.* p. 12. This is also contrary to the emergency department treatment record signed by Nurse "B. Petty" which reads, "Pt [Patient] states hurts to

breath in since yesterday." *Supp. App.* p. 6. Petitioners appealed to the Tenth Circuit that this evidence strongly suggested document tampering and misrepresentation of Mr. Phillips' true presentation to Hillcrest. *See Appellant's Opening Brief, App.* p. 91 - p. 111.

Dr. Cobb continued to be contradicted at trial. According to Dr. Cobb, she dictated her examination of Mr. Phillips two days after his September 23rd 1998 presentation to the Hillcrest emergency room. *App. p. 208, ln 3-17.* To create this dictation, Dr. Cobb testified she utilized two documents, which she took home with her, the "face sheet" and the "review of systems" sheet. *Id.* Neither of these two sheets contain the precise vital signs of blood pressure 129/55, pulse rate 112, respirations 16, and temperature 98, yet; these show up in her dictation. *Supp. App.* pp. 4, 10, 12, 13; Not only do these precise vital sign readings show up in her dictation, but also do many other clinical symptoms not on those two pages she claims to have utilized for her dictation. Regarding "Heent" (i.e., head, eyes, ears, nose, and throat), Dr. Cobb dictates, "Pupils are equal, round and reactive to light. Gaze is conjugate". *Supp. App.* p. 12. Regarding lungs: "Clear lungs to auscultation. No increased respiratory effort." *Id.* None of which are on these two sheets, *supra.* This evidence shows Dr. Cobb did not only utilize these two sheets for her dictation effort, and is misrepresenting her conduct.

Additionally, not only have witnesses Michael Dacewitz and Dr. Phillip Murta contradicted her assertion at trial and in her dictation that Mr. Phillips' lungs were clear when she examined him, but, she contradicted her own dictation with her dictation. For instance, in patient history regarding Mr. Phillips' neck she stated, "The neck has been stiff for nearly three weeks. It is painful to try to turn it from side to side." *Supp. App.* p. 12. Then she stated in a different portion of her dictation, "Full movement of his neck is noted. *Id.* Also, regarding Mr. Phillips' vital signs, Dr. Cobb states his heart rate was 112 beats per minute. *Id.* All parties admitted a pulse rate of 112 is tachycardia, an abnormally fast heart rate. *App.* p.

210, ln 18; p. 240, ln 4-16. Yet, regarding the heart Dr. Cobb dictates, "Rate is regular". *Supp. App.* p. 12. This evidence shows Dr. Cobb, under the pressure of learning of Mr. Phillips' death, likely attempted to reconstruct and piece together a semblance of an examination of Mr. Phillips, which never took place.

At trial, evidence further showed that within one week of Mr. Phillips' death, Hillcrest's "risk management" team had begun protecting Hillcrest's interests; the medical director for Hillcrest, had been notified of Mr. Phillips' death at its sister hospital; and, he triggered an investigation requiring Mr. Phillips' medical file to be examined, the purpose of which according to Hillcrest's medical director, was "to make sure everything looked okay". *App. p. 246 ln 12-23, p. 245; ln 1-5, p. 244, ln 15.* Evidence showed that the emergency department admission policy, in effect since July 24th 1995, was changed on September 30th 1998, two days after Mr. Phillips died at TRMC, Hillcrest's sister hospital. *Supp. App.* p. 28; p. 20. According to this policy, prior to September 30, 1998, nurses performed the medical examination. *Id.* After Mr. Phillips died, it now reads, "Under no circumstances is any patient to be refused treatment or referred to another facility without 'a medical screening exam by an E.D. physician'". *Id.* This attests to why nothing is written in the "Emergency Dept. Treatment Record" and the spaces are blank as to: "physician's report"; "physical exam"; "time" patient was seen; "initial impression"; left and right "visual acuity"; and why no new vital signs other than those taken by the initial triage nurse appear in the chart, because no exam was done by Dr. Cobb, but only the triage nurse. *Supp. App.* p. 6, p. 8; and *Supp. App.* p. 28.

Moreover at trial, Hillcrest veracity was again at issue when Petitioner's presented evidence in Hillcrest's triage policy and procedure manual. Shanna Delsorbo, Hillcrest's emergency room manager, after having authenticated that the triage policy and procedure manual was in effect at the time Mr. Phillips presented to Hillcrest emergency room, when questioned about page six (6) of that manual, where it reveals Hillcrest has a

strong aversion to those without insurance or the ability to pay, Ms. Delsorbo testified that particular policy was not in effect on the date of Mr. Phillips' presentation. *App.* p. 187, ln 24- p. 188, ln 25; p. 189, ln 2-14; p. 190, ln 1-22. This policy states for patients classified in triage category III*, "These patients will be ***strongly encouraged*** to accept clinic referral unless they have proof of insurance coverage." *See Triage Manual, Supp. App. p. 26, para. 2.* Petitioners took issue with Ms. Delsorbo's credibility as to whether the policy was in effect, and it was a fact question creating suspicion of a very hard line that Hillcrest takes against those without the ability to pay. This was unless of course one was an employee or family member, because this manual, on its next page, goes on to state, "All Hillcrest Medical Center employees will be seen regardless of triage category or ability to pay...[t]his will also apply to any employee's family members." *Id. at Supp. App. p. 27, para. 6.* Evidence showed Hillcrest, had a discriminatory attitude.

Pursuant to Hillcrest policy, if a person has chest pain and appears ill, that patient is categorized as a category I. *Supp. App.* p. 21. Mr. Phillips was triaged as a category III and sent to the minor care side of the emergency department. *See Minor Care Register, Supp. App.* 8, and *See* p. 8 (category III). Category I and II patients are both considered emergencies under Hillcrest policy, and go to the emergency side of the emergency department where more extensive testing is done. *App.* p. 220, ln 20-25. Petitioners presented powerful evidence that Mr. Phillips, in addition to his chest pain, appeared seriously ill during the Hillcrest emergency visit. James Cooper, Micheal Dacezwitz, Barbara Hight, and Michael Lulka, witnesses presented by Petitioners, all saw Mr. Phillips just prior to, the same day, or in the emergency room of Hillcrest, and in varying lay witness or medically trained descriptions, all agree that Mr. Phillips looked very ill, and not well. *App.* p. 250, ln 22- p. 251, ln 3; p. 172 ln 10- p. 173, ln 19; p. 177, ln 9-11; p. 179, ln 14-24; p. 191, ln 25- p. 193, ln 24. James Cooper, an emergency medical technician, testified he has seen many sick individuals in that line of work, and described Mr. Phillips prior to the Hillcrest visit as "the walking dead". *App.* p. 251, ln

2-3, p. 199, ln 2-6. This evidence starkly contrasts Hillcrest's version of Mr. Phillips' condition on his presentation.

At trial, evidence mounted suggesting Hillcrest mendacity. Christina Dacewitz, the mother of Mr. Phillips' only child, testified when she visited Hillcrest in mid-October 1998 in an attempt to obtain the medical chart on Mr. Phillips, she was shown the original "face sheet" for his medical chart, where just below "next of kin" in the space for "Insurance" information, written in a woman's handwriting, were the words, "No Insurance". *App. p. 255, ln 10-24; p. 256, ln 3-23; p. 257, ln 8-15.* This "face sheet" with the handwritten version of "No Insurance" was not provided in Mr. Phillips' medical chart prepared by Hillcrest; only the type written one, that one is now blank in that particular space. *Supp. App.* p. 4. Hillcrest has a policy for shredding these face sheets. *Supp. App.* p. 35. Further evidence provided strong inference of sinister conduct. A second triage intake sheet, provided in a mountain of documentary discovery and admitted into evidence as Plaintiffs' exhibit 45, likely the original triage sheet pertaining to Mr. Phillips, revealed readily observable liquid paper white-out and/or erasure marks. *Supp. App.* p. 24. This evidence strongly suggested, that once Hillcrest learned of Mr. Phillips' death at its sister hospital, an attempt was made by Hillcrest to change Mr. Phillips' clinical presentation in hope of causing the medical chart to more readily line up with EMTALA requirements. Changes and additions to Mr. Phillips' medical chart explain why there are so many contradictions in Dr. Cobb's testimony and dictation, *supra.*

In the midst of the disturbing contradictions of Dr. Cobb's testimony and dictation; and, her ability to dictate a running list of precise vital signs two days after allegedly evaluating Mr. Phillips without the documents containing that information; as well as trial exhibit 45 and the missing face sheet with a woman's handwriting, is another disturbing fact. The "review of systems" sheet, a medical intake questionnaire which Hillcrest represents is a part of Mr. Phillips' medical chart, and is one of the two documents Dr. Cobb testified she took home

with her, *supra*, is not signed by Mr. Phillips in the location for the patient's signature. *Supp. App.* p. 10. One answer on this sheet created Hillcrest and Dr. Cobb's only affirmative defense to Petitioner's state pendent claim for negligence brought in the Northern District under supplemental jurisdiction. *App.* p. 271- p. 274.

Mr. Phillips had died of septicemia, (i.e., bacteria in the blood), and complications with bacterial endocarditis, an infection of the heart. *Supp. App.* p. 20. Although Petitioner's never alleged Dr. Cobb was negligent for failing to diagnose bacterial endocarditis or septicemia, the trial court allowed Hillcrest and Dr. Cobb to claim she could not diagnose this disease without a "truthful" answer to the following question on this questionnaire, "Do you use drugs not prescribed by a Physician?" *Id., and App.* p. 271- p. 274. The box was not checked, but was instead, slashed, "No." *Id.* From question sixteen (16) through question forty-two (42), one straight line was drawn through this lengthy column of "No" boxes. *Id.* There is neither one "✔"; nor one "✖", on the entire questionnaire of over sixty (60) questions requiring a mark in a box. *Supp. App. p. 20.* All marks utilized for a response on this questionnaire are either swiftly made hashes, a straight continuing vertical line through succeeding boxes, or rapidly made loops. *Id.* In places requiring words to be written, there are none, but only rapidly made horizontal lines indicating a negative response. *Id.* This document highlights only one thing, it was filled out by someone familiar with the form, and it was not Martin Shane Phillips. *Id.* The only signature present is Dr. Cobb's. *Id.*

Evidence shows Hillcrest had a plan and a way to put the blame of Mr. Phillips' death on Mr. Phillips. On September 28th 1998, 4.5 days after the Hillcrest emergency room visit, at Hillcrest's sister hospital TRMC, in the midst of crying out on his death gurney, "Help me", "Help me", Mr. Phillips was asked by Dr. Phillip Murta, "Do you use drugs?" His response in this life and death answer was, "No". *App.* p. 232, ln 14-15, p. 185, ln 18-20. Dr. Murta's first impression of Mr. Phillips

upon his presentation to TRMC, was that Mr. Phillips was "about ready to die", and he testified he felt Mr. Phillips was not trying to hide anything about his medical history. *App.* p. 182, ln 13-17, p. 185, ln 3. According to Dr. Murta, Mr. Phillips informed him he had been to Hillcrest within one-week prior with similar symptoms. *App.* p. 183 ln 21- p. 184, ln 9. Therefore, at that time, TRMC had knowledge that Mr. Phillips had been to its sister hospital within a week prior with similar symptoms, was discharged, and was now about to die. *Id.*

At 7:00 a.m., two hours and twenty-two minutes before Martin Shane Phillips was pronounced dead, Dr. Stan Stacy came on duty, relieving Dr. Phillip Murta. *See Murta's dictation, Supp. App.* p. 43. After Mr. Phillips' father, Fred Phillips, had already been informed his son would likely die, Dr. Stan Stacy continued to inquire whether Mr. Phillips was a user of drugs and asked him to find out. *Id., See Also App.* p. 228, ln 7- 229 ln 2. In an attempt to find out, Fred Phillips phoned his son's place of work, the man answering the phone had no knowledge of such, and went about the complex inquiring. *App.* p. 230 ln 8-22. Upon this man's return, the man repeated what he was told by someone else in the complex that, Mr. Phillips "may have snorted some crack." *Id.* Fred Phillips testified he then, "told [Dr. Stan Stacy] exactly what the man told me that [Mr. Phillips] <u>might</u> have snorted some crack. That's exactly what I told the doctor". *App.* p. 231 ln 15-18. On October 1, 1998, one day <u>after</u> Hillcrest made changes to its emergency department admissions policy requiring a physician to perform the medical screening and evaluation instead of a nurse, *supra*, Dr. Stacy dictated "[Patient] evidently denied drug use to the previous shift. However, his father had contacted the patient's work place and they did confess that the patient <u>has</u> a history of methamphetamine abuse." *Supp. App.* p. 44. Fred Phillips' statement that his son "might" have snorted crack, in Dr. Stacy's dictation, then became a historical fact based only on a statement made to Dr. Stacy not as a fact, but as a past possibility. The fact Dr. Stacy's dictation was one day after Hillcrest changed its admissions policy, shows Hillcrest was on

the "move" and likely persuaded Dr. Stacy and TRMC how to protect their sister.[2]

This evidence links Hillcrest, and TRMC, the sister hospitals, in a concocted plan to blame Mr. Phillips for his own death alleging he failed to inform Hillcrest and Dr. Cobb that he "is" a drug user, and therefore, Mr. Phillips caused his own death because Dr. Cobb could not successfully diagnose the disease process without this information. *App.* p. 271- p. 274. This is how Hillcrest created its "out" for failing to do anything for Mr. Phillips. Able to discuss, cooperate, exchange information, and observe the records of its sister hospital, Hillcrest, Dr. Cobb, TRMC, and Dr. Stacy, conspired to remedy Hillcrest's shortcomings of September 23rd 1998, *supra*, and minimize or preclude liability by creating or recreating this questionnaire, called the "review of systems" sheet. In that one document, not signed by Mr. Phillips and certainly not filled out by him, *supra*, the response to that one question about whether Mr. Phillips is a user of drugs, created Hillcrest's only affirmative defense against Petitioners' negligence action. *Id.*, and *Supp. App.* p. 10. Solidifying these links is the fact that Mr. Phillips died at TRMC, yet the death certificate signed by Dr. Stan Stacy of TRMC was in the medical chart originating from and provided by Hillcrest to Petitioners. *Supp. App.* p. 20. This Court may readily observe the bate stamp "HMC0279", on Mr. Phillips' death certificate, at *Id.*, which contains the acronym for Hillcrest Medical Center. This death certificate of Martin Shane Phillips in the Hillcrest medical chart is likened to the "smoking gun", and strongly corroborates the logic of these events. *Id.*

Concerning Mr. Phillips' "tremendous" chest pain, such that on the way to the hospital, it caused him to clench in pain; that even the slightest movement or bump in the car would increase the pain; and, such that in the emergency room it caused him to slump over holding his chest with tears in his eyes; and, such

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[2] Hillcrest medical director, Dr. Steven Landgarten, is also head of Hillcrest Healthcare System, which owns and operates Tulsa Regional Medical Center, "TRMC".

that Dr. Cobb herself confessed his "obvious" distress, giving him "several days off of work for him to rest", no diagnosis whatsoever was made to determine if this medical condition manifesting itself by severe chest pain, with tachycardia, (i.e., abnormally fast heartbeat), "such that the absence of immediate medical attention could reasonably be expected to result in" — (i) placing Mr. Phillips health in serious jeopardy, (ii) serious impairment to his bodily functions, or (iii) serious dysfunction of any of his bodily organs or parts. *See* § 1395dd(e)(1)(A); *App.* p. 192, ln 3-4; p. 194 ln 3-17; p. 195, ln 18-20; p. 258, ln 2-7; p. 216, ln 14-16. Evidence shows not once did Hillcrest screen Mr. Phillips as is required by § 1395dd(a) in congruence with § 1395dd(e)(1), to determine what was causing his "Pleuritic Type Chest Pain", (i.e., pain which arises from the pleura). *See Dr. Cobb' Impression in her dictation Supp. App. p. 12; See also App.* p. 263, ln 16-17 (pleuritic chest pain defined). "Pleuritic Type Chest Pain" is the label Dr. Cobb placed on her final impression. *App.* p. 211, ln 22 – p. 212 ln 2; *Supp. App.* p. 12. However, pleuritic chest pain is not a cause; it is a symptom, yet Dr Cobb, in a sneaky way, pretended it to be the cause of Mr. Phillips' chest pain. *App.* p. 237, 1-3. Dr. Cobb never determined the cause of Mr. Phillips' symptom of pleuritic chest pain, *infra*, and yet discharged (i.e.," transferred" as defined by § 1395dd(e)(4)) Mr. Phillips "reasonably" knowing this chest pain could be placing his health in serious jeopardy contrary to the requirement of § 1395dd(e)(1). *See* § 1395dd(e)(1), *et seq.*

Petitioners' medical expert, Dr. Benjamin Zola ("Dr. Zola") concluded: "[T]here is complaint of chest pain...hurting to breath in and out. During the physical exam there is nothing...on the chart that specifically relates to whether or not this patient...there's nothing on the lungs, there's nothing mentioned on the chest to determine whether or not the patient's chest was actually examined... was there any specific point on the chest that was tender, that was painful... If there was going to be pleuritic type pain, then a reason for that pleuritic type chest pain had to be sought out and determined... many things cause pleuritic chest pain...[it] can be potentially dangerous and

life threatening ... those were never investigated or commented upon." *App. p. 233, ln 7- p. 235, ln 25.* Dr. Zola further opined, "it's not enough to just list an impression, it actually needs to be investigated and looked into". *App. p. 237, 1-3.* All Dr. Cobb did, was list what Mr. Phillips' complaint was, as her diagnoses or final "Impression". *See Dr. Cobb's Impression in her dictation, Supp. App.* p. 12; *Also p. 211, ln 24- p. 212, ln 2.* To say, "Mr. Phillips you have pain coming from your pleura", and not determine its cause, is to fail to determine if it is an emergency medical condition.

The reality of what Dr. Cobb did not do, is to imagine if she only listed an "impression" of "heart pain", and made no investigation by testing or otherwise, to determine the underlying cause of such heart pain, and made no conclusion as to its underlying cause; but only stated, "Mr. Phillips has heart pain". The undisputed fact reveals that the emergency department "treatment" record for Mr. Phillips is completely blank in all significant respects for which a physician is to consider, assess and complete a patient evaluation, *supra. See* also, *Supp. App.* p. 6. According to her dictation, Dr. Cobb's "Impression" was not dictated until September 25th 1998, two days after she allegedly saw Mr. Phillips on the 23rd. *See Supp. App.* p. 12. The discharge sheet for Mr. Phillips, that Dr. Cobb claims to have filled out herself, lists only "cervical spasms" as Dr. Cobb's only impression upon his discharge and mentions nothing about chest pain. *See Supp. App.* p. 15; *See also, App.* p. 209, ln 8. All of this evidence tends to prove that on the 23rd of September, Hillcrest made no diagnosis for the chest pain before it discharged (i.e., transferred, as defined in § 1395dd(e)(4)) Mr. Phillips to make an appointment with a clinic for those without insurance.[3] Additionally, considering the substantive proof of document tampering, *supra*, it is likely, the

[3] Hillcrest's employee responsible for emergency room patient processing, when asked, Q: "What does the question mark mean based off your training and experience at Hillcrest Medical Center?" A: "I'm sorry, it looks to me that they didn't have a diagnosis to put in there." *App.* p. 219, ln 10-14; p. 218, ln 17-19.

date of dictation indicated on Dr. Cobb's dictation, is untruthful, and was done, at least in part, after Hillcrest learned of Mr. Phillips' death. Therefore a reasonable inference is that Dr. Cobb never made any "impression" as to Mr. Phillips' chest pain, but only later created the appearance, for necessity and the need for Hillcrest to have a record that a physician saw him.[4]

At trial, Dr. Cobb, consistent with Petitioner's expert, admitted that many things cause chest pain.

> It's a long list and it comes from many different causes. Chest pain, and I think the one most people think of first is a heart attack. It can come from the heart. You can also have pericarditis which is an inflammation around the heart. Pneumonia. An infection in the lungs can cause chest pain. You can have a pneumothorax which is a collapsed lung where there is air that has filled the pleural space between the lung and the chest wall that causes chest pain. *App. p. 214, ln 4-11.*

Though Dr. Cobb admitted the above were possibilities during her evaluation process as to the cause of Mr. Phillips' chest pain, she never determined the cause for the "Pleuritic Type Chest Pain", and neither was its cause mentioned in her diction, nor her testimony, when even by her own admission, in the last sentence of her above quoted testimony, "pleural" or "Pleuritic Type Chest Pain", could be associated with a collapsing lung. *Id., See also, Supp. App.* p. 12. Assuming Dr. Cobb even examined Mr. Phillips, the most she did regarding this chest pain, was to dictate the pain itself was pleuritic, (i.e., pain arising from the pleura), but never determined its cause. Id., *Also, App.* p. 263, ln 16-17. As Petitioners' expert Dr. Zola explained an impression of pleuritic chest pain is not a diagnoses or an underlying cause, when he stated "it's not

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[4] Hillcrest admission policy, though in effect on the date of Mr. Phillips' presentation, was changed two days after his death at Hillcrest's sister hospital, TRMC. After Mr. Phillips' death, it now requires a physician to perform the medical screening exam, rather than a triage nurse. *See Supp. App.* p. 28.

enough to just list an impression, it actually needs to be investigated and looked into". *App. p. 237, 1-3.* "If there was going to be pleuritic type pain, then a reason for that pleuritic type chest pain had to be sought out and determined... many things cause pleuritic type chest pain...[it] can be potentially dangerous and life threatening ... those were never investigated or commented upon." App. *p. 233, ln 15- p. 235 ln 25.* This proves that there was no "appropriate medical screening" because § 1395dd(e)(1) requires immediate medical attention if its absence could reasonably be expected to result in seriously jeopardizing Mr. Phillips' health. *See* § 1395dd(e)(1), *et seq.* Dr. Cobb admitted herself that chest pain could be caused by many things, including a heart attack, even a collapsing lung, yet never did anything to determined its cause, and transferred Mr. Phillips to the clinic for those with no insurance. *App. p. 206, ln 25 – p. 207, ln 5*; p. 267, ln 13- p. 268, ln 23. By Dr. Cobb's choice not to test or investigate the cause of this "Pleuritic Type Chest Pain", she chose not to provide an "appropriate medical screening" as is required by § 1395dd(a) to determine the existence of an emergency medical condition within the meaning of § 1395dd(e)(1).

At trial, the following exchanges occurred in Dr. Cobb's testimony:

> Q: Yes. Is there a simple diagnostic test that you can do to determine whether a person has infection in their blood or not? A: It is possible to order blood cultures to see if there's infection in the blood. Q: Yes. And blood cultures are the gold standard; aren't they? A: Yes. *App.* p. 202, ln 20 – p. 203, ln 1.
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> .....
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> Q: And at the time you examined him and you considered that he could have septicemia you knew that you could order blood work? A: Mr. Toon, when I examined Mr. Phillips I could order anything that was indicated. Q: Yes. And Hillcrest allows you to order diagnostic tests in the emergency room; don't they? A: Hillcrest allows me to order diagnostic tests of course. Q: And a blood work

or blood count, those are both simple tests; aren't they? A: Those are simple tests. They can be easily done, yes. Q: And EKGs can be easily ordered and done; correct? A: An EKG can be easily ordered and done. Q: Chest x-ray is an easy test to order also; correct? A: I can order any test. I can order a chest x-ray. *App.* 204, ln 18 – p. 206, ln 1.

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Q: On September 23 of 1998, Doctor, did you confirm that Martin Phillips did not have septicemia? A: I guess that would mean – you are using the word confirm. My clinical evaluation did not indicate that. Q: And your clinical evaluation was just your physical exam of him, looking him over? A: The medical evaluation consists of several parts. The first part being the history. Physical examination is a part of the evaluation and also the circumstances surrounding your seeing the patient. *App.* p. 206, ln 21- p. 207, ln 5.

Though Mr. Phillips died of septicemia, (i.e., a blood infection), and Dr. Cobb considered septicemia in her working diagnosis as a possible cause of Mr. Phillips pain, and her expert testified that the disease process that killed Mr. Phillips was proliferating at the time of his presentation to Hillcrest; Dr. Cobb chose not to order a blood test; which she testified to be the "gold standard" for determining if a patient has a blood infection; was a simple test; easily done; and, that she was authorized to order it. *App.* p. 202, ln 20 – p. 203, ln 1; p. 262, ln 7-13; p. 265, ln 3-18; p. 204, ln 18-25.

There is a question mark, "?", written on the emergency room log in the space where the description of the final disposition of the patient is to be written; and this question mark, "?", is exactly next to Mr. Phillips' "departure time" of "1625" hours, which is 4:25 p.m. *See Supp. App. p. 23; App. p. 219, ln 10-14.* Hillcrest's employee responsible for emergency room patient processing, when asked, Q: "What does the question mark mean based off your training and experience at Hillcrest Medical Center?" A: "I'm sorry, it looks to me that

they didn't have a diagnosis to put in there." This shows that Mr. Phillips was never diagnosed; that Hillcrest knew he was not diagnosed; and that no determination was made whether he had an emergency medical condition as is defined in § 1395dd(e)(1). As previously addressed, *supra,* Mr. Phillips died on a gurney at TRMC, Hillcrest's sister hospital, crying out "Help me, help me." *App.* p. 232, ln 14-15. That was Monday, September 28th 1998. *Supp. App.* p. 20. Mr. Phillips had spent that previous weekend attempting to obtain a doctor's appointment, by and through relatives. *App.* p. 224, ln 22- p. 225 ln 1; p. 227, ln 7-18. Mr. Phillips was unable to secure an appointment prior to his death. *Id.* The bottom right of the discharge sheet from Hillcrest reads, "Doctor Referral Information: OU Family Practice".[5] *Supp. App.* p. 15.

The battle in this case at trial was over Mr. Phillips' "perceived" physical appearance. Dr. Cobb in her testimony at trial would only say that Mr. Phillips' evaluation did not indicate the need for any tests or to do anything further, which is another way of saying, had she "perceived" his physical symptoms of illness, then some diagnostic tests would have been done. *App. p. 214, ln 18 – p. 215, ln 1.* Yet, the plueritic chest pain which Dr. Cobb, did perceive, was left unchecked, undetermined, and without an "appropriate medical screening". *App.* p. 233, ln 15- p. 235, ln 25.

It is this dispute over a patient's appearance and the holding of both the trial court and, now the Tenth Circuit which sets growing precedent eliminating virtually every cause of action under 42 U.S.C. § 1395dd(a) through § 1395dd(d). Under this

[5] Hillcrest, the one hospital which should have helped him, likely left Mr. Phillips with the belief that he could not go to another hospital emergency room for treatment due to the fact that he was referred to make an appointment to a facility for those without insurance or ability to pay, but was left with the sole option to wait on the OU Family Practice appointment or to seek a willing doctor in private practice to see him without an insurance card, who had no obligation under EMTALA to render him care. *See* 42 U.S.C. § 1395dd(d)(2)(Enforcement provisions apply to "participating hospital[s]" only).

newly articulated standard, only in the rare instance where hospital personnel readily admit to their own violation of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), will a cause of action and token enforcement of a hospital's duties under § 1395dd, *et seq.*, be available. See *Repp v. Anadarko, 43 F.3d 519, 522*, (C.A.10 1994); *See Also Phillips* at 797; Appellant's Opening Brief to the Tenth Circuit, *App.* p. 91- p. 111 (Evidence of intentional dumping presented and trial court's granting of Rule 50 affirmed with "perceived" standard pronounced. *Phillips* at 797).

REASONS FOR GRANTING THE WRIT

I. THE COURTS OF APPEAL ARE SPLIT ON THEIR INTERPRETATION AND APPLICATION OF 42 U.S.C. § 1395dd(a)

This Court in *Roberts v. Galen*, 525 U.S. 249, 253, 119 S.Ct. 685,687 (1999) recognized the split of the circuits in the application of § 1395dd(a) when this Court stated, "We note, however, that Cleland's interpretation of subsection (a) of EMTALA is in conflict with the law of other circuits which do not read subsection (a) as imposing an improper motive requirement." *Id* at n. 5. This Court then sighted these various cases and circuits conflicting with the Sixth Circuit:

> See *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137-*38 (C.A.8 1996)(en banc); Correa v. Hospital SanFrancisco*, 69 F.3d 1184, 1193-94 (C.A.1 1995); *Repp v. Andarko Mun. Hosp.*, 43 F.3d 519, 522 (C.A.10 1994): *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 857 (C.A.4 1994); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041(C.A.D.C.1991).

In *Roberts*, this Court considered § 1395dd(b) and whether its stabilizing provisions required an improper motive, and noted that § 1395dd(a) and its "appropriate medical screening requirement is not before us". *Roberts* at 253, 687.

In form, all of these circuits, in one way or another, hold uniform treatment to be the benchmark for a violation of § 1395dd(a)'s "appropriate medical screening" requirement. *See Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, (C.A.6 1990) (Stating "this statute applies to any and all patients."); *See Repp* at 522 (Stating, "[A] hospital violates [§] 1395dd(a) when it does not follow its own standard procedures"--meaning these procedures shall apply to all patients). *See Summers* at 1138 (Stating, "[I]t is up to the hospital ...to determine its procedures, ... having done so, it must apply them alike to all patients).

Although uniform treatment appears to be the goal of the circuits, the catch is, the various circuits, in an effort not to create a federal negligence cause of action, are articulating, even illogical rulings as it pertains to § 1395dd(a), and this uniform treatment. For instance, in *Phillips,* the Tenth Circuit, though it acknowledges that "disparate" treatment is the "linchpin" of EMTALA and that § 1395dd(a) "undeniably" requires Hillcrest to "apply uniform screening procedures to all individuals coming to the emergency room", it now says that if medical personnel fail to "perceive" a patient's medical symptoms or illness, then there is no liability under § 1395dd(a). *Phillips,* 244 F.3d at 797 (2001). *See also Vickers v. Nash General,* 78 F.3d a139, 144 (C.A.4 1995)("...taking the actual diagnosis as given"). This means that patients whose symptoms are not "perceived" will be treated differently; that these actions will be protected; and that, is "undeniably" contrary to this "linchpin" standard. *Id.* The Tenth Circuit, as well as others, have sensed this paradox in times of hope for §1395dd, *et. seq.,* and have gone as far as to say that an EMTALA violation yields "strict liability" for the violating hospital. *Abercrombie v. Osteopathic Hosp. Founders Ass'n,* 950 F.2d 676, 681 (C.A.10 1991); *See Summers* at 1137, 1138 (C.A.8 1996). Strict liability, by its nature should mean there is no mitigation that eliminates the offense once it has occurred. Yet, the Tenth Circuit, in *Phillips*, has mitigated this "strict liability" principle, to mean, there is no liability if hospital personnel testify they did not follow hospital policies because

they did not "perceive" a patient's appearance or symptoms triggering the operation of a procedure to be applied. *Phillips* at 797. Hence, uniform treatment is not a true "linchpin".

Additionally, the facts of intentional conduct in the case at bar, presumably, were considered by the Tenth Circuit in rendering its opinion in *Phillips v. Hillcrest*, 244 F.3d 790 (C.A.10 2001), and it therefore appears that such a "perceived" standard is being held as a subjective test, not subject to scrutiny or challenge for the truth of the "perception". [6]

However, the Fourth Circuit appears to utilize, at least a more fair approach, and allows rebuttal evidence to challenge the medical representations, albeit, maybe only through a plaintiff's medical expert. *Power v. Arlington Hospital Association,* 42 F.3d 851, 858 (C.A.4 1994); *But see Vickers* at 144, ("...tak[ing] the actual diagnosis as a given"). Wherever the line may be, it is evident and paramount that the circuits are in need of supervisory guidance on the issue of how liability shall be found under § 1395dd(a). Not only is confusion present as to whether a certain motive needs to be present, it is evident the circuits are striving, even between "strict liability" and no liability, merely when physicians or medical personnel say they are not liable. *Id.*, and *Phillips* at 797. Causing representations by medical personnel to be taken as true, this new "perceived" standard even violates the long held tenant that a witness, by taking the stand puts his credibility at issue and is subject to the scrutiny of cross-examination. *See United States v. Havens, 446 U.S. 620, 626-27, 100 S.Ct. 1912, (1980)*, ("It is essential, therefore, to the proper functioning of the adversary

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[6] In spite of the Tenth Circuit's admission that an appeal for the granting of a Rule 50 motion is reviewed "denovo", and that the Tenth Circuit could affirm the trial court's decision only if the facts presented for Petitioners' claim for intentional violation of EMTALA pointed in favor of Hillcrest and were not "susceptible to [any] reasonable inferences supporting" the Petitioners, it took as true the "perceptions" of the three Hillcrest personnel who allegedly came into contact with Mr. Phillips", even though there was serious evidence, *supra*, contradicting the veracity of these perceptions. *Phillips* at 796 and 797.

system that when a defendant takes the stand, the [plaintiff] be permitted proper and effective cross-examination in an attempt to elicit the truth."; *See also U.S. v. Tomlin,* 46 F.3d 1369, 1390 (C.A.5 1995) (taking the stand places a witness's credibility at issue). Hence, the confusion overlaying § 1395dd(a) encroaches even the barest essential of trial advocacy and this Court should intervene, striking down this "perceived" standard.

II. THE TENTH CIRCUIT'S DECISION WILL CAUSE IRREPARABLE HARM TO, AND PUT AT RISK, A LARGE POPULATION OF THIS COUNTRY'S CITIZENS WHO PRESENT TO EMERGENCY ROOMS SEEKING HELP FOR EMERGENCY MEDICAL CONDITIONS

This is a nationally important question, as it relates to the health care of our nation and the protection of our citizens and their rights to emergency medical care. This newly articulated "perceived" standard with which the Tenth Circuit replaced Congress' original medical examination in § 1395dd(a) as meant in § 1395dd(e)(1), will seriously affect, diminish, and retard the medical attention to be received, and needed, by the populous that Congress saw the need to protect; and, for which it created and implemented § 1395dd(a) in the first place. The Tenth Circuit's holding, emits precedent throughout the other circuits in an atmosphere among circuits that are no longer looking to the plain meaning of § 1395dd(a), which requires a hospital to provide an appropriate medical screening examination to determine whether (within the meaning of subsection (e)(1)) (A) "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in"— (i) placing the health of the individual in serious jeopardy, or (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. *See* § 1395dd(e)(1)(A) *et. seq.* At least for the entire population in the Tenth Circuit, no legal redress and hence, no deterrent is available, even when standard hospital emergency room procedures are violated, as long as the pertinent medical

personnel testify they never "perceived" a patient's condition.[7] This occurred in a jurisdiction which reiterated its holding in the following words, " 'disparate treatment' is simply another term for describing or measuring a hospital's duty to abide by its established procedures." *Phillips* at 797.

This "perceived" standard is a threat to the welfare and safety of all in the Tenth Circuit and the other circuits allowing subjective testimony to stand beyond the reproach of scrutiny. *See Phillips* at 797; *See Vickers* at 144 (taking as true the medical personnel's version of the facts). "We just didn't "perceive" the need to give them any medical attention"; is the pervading response for those hospitals seeking to avoid EMTALA's responsibility and liability; and, is exactly what Hillcrest did to Mr. Phillips, and he died. This new precedent over-writes Congress' intent in a dangerous way and the lives of the people Congress so carefully designed to protect when promulgating § 1395dd(a), are now at risk. This not only violates separation of powers, by rewriting Congress's legislative intent, as it allows intentional conduct to go unchallenged, it opens the door to inconsistent health care, serious organ and bodily detriments, and the possible death of many patients, that for whatever reason, are not "perceived" to be ill, because it removes the penalty of EMTALA, as well as any uniform treatment requirement, and a hospital's motivation to deal fairly. Therefore, the right Congress had guaranteed of many to receive an appropriate medical screening to <u>determine</u> (within the meaning of subsection (e)(1)) whether or not a medical emergency exists placing the health of the individual in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part, will remain lost if the "perceived" standard is upheld. This "perceived" standard

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[7] The Tenth Circuit was presented the fact that the trial court admitted policies were violated. *App.* p. 47, ln 11-13; p. 40, ln 11-24. The trial court had granted the Rule 50 even after admitting that the evidence was a question of fact regarding Mr. Phillips' appearance which would obligate Hillcrest to provide additional care under its policies, reasoning that 42 U.S.C. § 1395dd(a) was an "undertaking" statute. *App.* p. 30, ln 4- p. 31 ln 4; p. 261, ln 1-7.

grants hospitals penalty free reign to discard the human lives that Congress so thoughtfully intended to protect.

At least prior to the newly articulated "perceived" standard in *Phillips v. Hillcrest,* 244 F.3d 790, (C.A.10 2001), as long as the standard medical policy and procedure involved was not a mere formality, (i.e., "de minimus"), EMTALA violations were committed when symptoms triggering the operation of procedures, were not executed. *Repp v. Anadarko,* 43 F.3d 519, 522, (C.A.10 1994). But this no longer holds true and is demonstrated thusly: If patient presents with "A", then do "B". However, if a hospital is of the aptitude of dishonesty to avoid the financial expense, in attempting to avoid liability, it masks an EMTALA violation by purposely minimizing symptoms in the medical chart to make it appear as though no medical emergency existed and testifying that "Based on the patient's ("perceived") symptoms, testing or treatment was not indicated." Therefore if "A" is reduced by misrepresentation, or any other reason, then, "B" is never triggered for execution. Congress saw the temptations that a doctor might have to misrepresent and minimize the true symptoms of a patient, and set out a civil cause of action as well as civil penalties for misrepresenting a patient's true condition. *See § 1395dd(d)(1)(B)(ii) and (d)(2)(A).* Because the "perceived" standard protects misrepresentations, intentional dumpings, and disregards uniform treatment, this new standard is dangerous to all subjected to it, and it should be struck down.

III.
THE TENTH CIRCUIT'S HOLDING DRASTICALLY DEPARTS FROM CONGRESS' ORIGINAL INTENT FOR 42 USC § 1395dd

Often referred to as the "Patient Anti-dumping Act", the purpose of EMTALA, was to address what has been characterized as a national epidemic of "dumping", which is the practice by hospitals of refusing emergency care to indigent patients who were at the door of the hospital, or transferring the patient to another hospital to avoid the absorption of the

medical cost by the dumping hospital. *Owens v. Nacogdoches County Hospital District 741 F.Supp.* 1269,1272 (E.D. Texas 1990). Intentionally refusing care because of a patient's status of indigency, is "the very evil which *§ 1395dd* was designed to prevent". *Id.* at 1271. Enacted by Congress as part of the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), and now codified as 42 U.S.C. § 1395dd, the legislative history of EMTALA set forth:

In *Brooks v. Maryland Gen. Hosp. Inc.*, 996 F.2d 708, 710, (C.A.4 1993), the Fourth Circuit recognized that under traditional state tort law, there was no obligation for a hospital to treat a patient who could not pay, and accordingly, Congress enacted EMTALA. Moreover, as stated in *Baber v. Hospital Corporation of America*, 977 F.2d 872, 880 (C.A.4 1992), "The avowed purpose of EMTALA was . . . to provide an '"adequate first response to a medical crisis'" for all patients and '"send a clear signal to the hospital community. . . that all Americans, regardless of wealth or status should know that a hospital will provide what services it can when they are truly in physical distress.'" (Citing 131 Cong. Rec. S13892-01 (Oct. 23, 1985)(quoting statements of Sen. Dole and Durenberger, respectively).

> In recent years there has been a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured. Although at least 22 states have enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists, and despite the fact that many state court rulings impose a common law duty on doctors and hospitals to provide necessary emergency care, some are convinced that the problem needs to be addressed by federal sanctions. 1986 U.S. Code Cong. Admin. News Vol. 3, p. 728.

Certainly, the impetus of Congress' intent in drafting § 1395dd was two-fold: 1.) to reproach patient dumping; and, 2.) to provide all Americans with an "adequate first response to a medical crisis". *Baber* at 880, and *Id.* This is evident in the

plain language of § 1395dd(a) which provides "if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency room..." Congress' intent for promulgating this statute goes beyond the "perceived" holding of the Tenth Circuit in *Phillips*, which cuts off liability for all claims where hospital personnel do not admit their folly. *Phillips* at 797. This holds true because policy violations, patient dumpings, and misrepresentations are consumed in this "perceived" standard. The test must not be that liability is always dependent on whether medical personnel "perceived" or did not "perceive" a physical symptom, otherwise the plain meaning of § 1395dd(a) where a hospital "must" determine a patient's condition in the meaning of (e)(1), is given no effect; Congress' intent is never fulfilled; and, a safe harbor is created for intentionally turning patients away, disguised as "I did not 'perceive' those symptoms", and thereby drastically departs from § 1395dd(a) 's purpose.

IV.
THE "PERCIEVED" STANDARD VIOLATES SEPARATION OF POWERS

The Tenth Circuit holds that a hospital's obligation under EMTALA is measured by whether it treats every patient "perceived" to have the same medical condition in the same manner. S*ee Phillips* at 797. This violates separation of powers, as it overwrites and forecloses on Congress' original intent for EMTALA. Under 1395dd(a) **a hospital is required** to give any individual (whether or not eligible for benefits under this subchapter) who comes to the emergency department and requests an examination or treatment for a medical condition. Clearly this section requires, as it states, **"the hospital must** provide for an appropriate medical screening examination...**to determine whether or not** an emergency medical condition **(within the meaning of subsection (e)(1) of this section) exists.** The term "emergency medical condition" means—(A) "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to

result in"—(i) placing the health of the individual in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. *See* § 1395dd(e)(1)(A). This is the original intent of Congress. *See Baber* at 880. (Citing 131 Cong. Rec. S13892-01 (Oct. 23, 1985)(quoting statement of Sen. Dole) (to provide an '"adequate first response to a medical crisis"' for all patients).

The original intent of Congress goes beyond any "perceived" standard to which the Tenth Circuit is now holding. Petitioners' addressed, *supra*, the intentional conduct of a hospital, where it intentionally overlooks symptoms, leaving documentation blank in all significant respects for a physician to consider, assess, and complete, as in this case, so that, at trial if any, the paper trail is left to a minimum. Yet the evidence in this case shows that the blank spaces speak louder than any words can as they proclaim that EMTALA has been violated because no determination has been made as to the emergency medical condition of this patient. Evidence shows that instead of a medical determination or diagnosis, there is a question mark (?) on the emergency room log for Mr. Phillips diagnosis, *supra*. How can the Tenth Circuit say that Hillcrest treated Mr. Phillips as it would have anyone else it "perceived" to be in his condition when Hillcrest was uncertain what his condition was? Even if it could, the "perceived" standard forecloses on Congress' original intent and violates separation of powers.

A violation of separation of powers occurred upon the holding of the Tenth Circuit's newly articulated "perceived" standard, replacing the mandatory medical screening required by Congress. *See* § 1395dd(a). No longer is an "appropriate medical screening examination" as defined in (e)(1) the requirement of EMTALA. *Id.* But instead, a hospital, pursuant to *Phillips*, is now only required to "perceive" or not "perceive" an illness or symptom. *Phillips* at 797.

This means if a symptom is "perceived" then that patient will receive testing and examination "to determine" whether that person has an emergency medical condition. *Id.* If a

symptom is not "perceived" then that patient will not receive testing and examination to determine whether that person has an emergency medical condition. *Id.* Petitioners believe that Congress' original intent is clear and needs to be upheld. However, whether the question of the newly articulated "perceived" standard, to which the Tenth Circuit is holding, preempts the original intent of Congress that the hospital must provide for an appropriate medical screening examination...to determine whether or not an emergency medical condition exists (within the meaning of subsection (e)(1) of this section) is an important question of federal law. Petitioners hereby appeal to this Court for a writ of certiorari pursuant to Rules of the Supreme Court, Rule 10(c), that a United States court of appeals has decided an important question of federal law that has not been, but should be, settled by this Court. *Rules of Supreme Court, Rule 10 (1999).* This Court has not, but we believe that it should settle this question.

V
PETITIONERS' RIGHTS VESTED UNDER 42 U.S.C § 1395dd WERE VIOLATED

The Tenth Circuit, by holding to its newly articulated "perceived standard", denied Petitioners' their right to be awarded damages under the laws of the State of Oklahoma. *See* 1395dd(d)(2)(B) and (d)(1)(B)(ii). This occurred when this "perceived" standard eliminated Petitioners' causes of action under Petitioners' presented evidence of misrepresentation, and intentional conduct *supra*. Under § 1395dd(d)(2)(A), Petitioners were entitled to damages for "violation of a requirement of this section", and under B(ii) Hillcrest through Dr. Cobb was liable for misrepresenting an individual's condition or other information, and were subject to civil money damages. *Id.*

CONCLUSION

Petitioners' felt they needed to impress upon this Court exactly what the Tenth Circuit overlooked, and this explains the fullness of factual content rather than the expanse of legal argument. Petitioners submit there can be no authority behind

something that is incorrect; and, review of the case law, will reveal that all of the circuits are not even addressing what § 1395dd(a) requires according to its language and Congressional purpose. As though each circuit does not have § 1395dd(a) to reference, the circuits appear to be referencing other circuits which also, are not addressing what § 1395dd(a) requires. It is a surreal view of the childhood game "telephone" where one child whispers to another and so on, until at the end of the line the last person says out loud what he/she heard, and everyone laughs because it is so far from anything that was originally said that it is humorous. However in this situation is not funny. People are being denied their right to an "appropriate medical screening" that Congress guaranteed them in § 1395dd(a), and they are dying. No circuit, in the viewpoint of Petitioners, has addressed Congress' intent. Instead one court builds upon another's misunderstanding, and the now "perceived" standard, addresses absolutely nothing in § 1395dd(a).

Section 1395dd(a) is the foundation for adequate medical care for people presenting to emergency rooms in a medical crisis. By allowing courts to undermine Congress' requirement is to uproot medical care for people in these United States. Congress' intent should be the foundation. If this foundation is not firm, it is shaky, and now so are the rights to "appropriate" medical care in an emergency crisis. The courts do not have the authority to rewrite § 1395dd(a). Const. Art. I § 1.

Once Congress promulgated § 1395dd(a), a right was vested in every citizen who enters an emergency room. The "perceived" standard has divested that right from those Congress intended to invest such right. Chief Justice Marshall once wrote that this Government "has been emphatically termed a government of laws, and not of men. It will certainly cease to deserve this high appellation, if the laws furnish no remedy for the violation of a vested right." *Marbury v. Madison,* 5 U.S. (1 Cranch) 137, 163, 2 L.Ed. 60 (1803).

Petitioners respectfully request this Court issue a writ of certiorari and strike down this "perceived" standard.

Respectfully Submitted,

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APPENDIX

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FILED
United States Court of Appeals
Tenth Circuit

MAR 26 2001

PATRICK FISHER
Clerk

PUBLISH

UNITED STATES COURT OF APPEALS

TENTH CIRCUIT

CRYSTAL STAR PHILLIPS, individually and as next of kin to Martin Shane Phillips, by and through her mother, legal guardian and next friend, MINNIE CHRISTINA DACZEWITZ; THE ESTATE OF MARTIN SHANE PHILLIPS; FRED MARTIN PHILLIPS, JR., parent of Martin Shane Phillips, Plaintiffs - Appellants, v. HILLCREST MEDICAL CENTER, an Oklahoma corporation doing business in the State of Oklahoma, Defendant - Appellee, and CAROLYN COBB, a physician; EMERGENCY PHYSICIANS, INC., an Oklahoma corporation doing business in the State of Oklahoma, Defendants.	No. 00-5013

Appeal from the United States District Court

for the Northern District of Oklahoma

(D.C. No. 98-CV-829-H)

Gregory Von Copeland, Tulsa, Oklahoma, for Plaintiffs-Appellants.

John R. Paul (Christy L. Butler with him on the brief), The Paul Law Firm, Tulsa, Oklahoma, for Defendant-Appellee.

Before **SEYMOUR**, Circuit Judge, **McWILLIAMS**, Senior Circuit Judge, and **BELOT**, District Judge.(*)

BELOT, District Judge.

Appellants filed this action alleging federal and supplemental Oklahoma state law claims. See 28 U.S.C. §§ 1331, 1367(a). Prior to submitting the case to the jury, the district court granted appellee's Rule 50 motion as to the federal claim. The jury returned a verdict in appellee's favor with respect to the supplemental state law claim. The appeal of the district court's final judgment is now properly before this court. See 28 U.S.C. § 1291. We affirm.

I. INTRODUCTION

A. Facts

On Wednesday, September 23,1998, Martin Shane Phillips, accompanied by his friend and co-worker Mike Lulka, walked into the emergency room of Hillcrest Medical Center (HMC). Phillips complained of severe chest pain and pneumonia-like symptoms. Prior to examining Phillips, HMC staff took background information from Phillips, including whether he was covered under any health insurance plan. Phillips claimed he was covered but could not locate his insurance card. Lulka, who was covered under the same plan from their mutual employer, offered his card to provide HMC administrative staff with the generic information that was equally applicable to the co-workers. HMC staff allegedly indicated on his file that Phillips was not insured.

After initial processing, Phillips was "triaged" by Lugenia Cue,[1] a registered nurse, and then examined by Dr. Carolyn Cobb in the minor care side of the emergency room. After the examination, Phillips was given two prescriptions, discharged from the emergency room, and referred to an Oklahoma medical clinic for follow-up treatment. Though his symptoms failed to subside, Phillips was seen at work on the two days (Thursday and Friday) following his discharge from HMC. Based upon all accounts, his condition was rapidly deteriorating through Saturday and Sunday.

Late Sunday night or early Monday morning, Fred Phillips, decedent's father, decided to take Phillips to the emergency room at Tulsa Regional Medical Center (TRMC). They arrived at TRMC, claiming Phillips had been suffering from nausea and vomiting for four to five days. Phillips again gave demographic information and denied, as he had on September 23, the use of illegal drugs. Phillips was initially examined by an emergency room doctor, Dr. Phillip Murta. Dr. Murta believed Phillips was suffering from pneumonia. Dr. Stan Stacy later relieved Dr. Murta and became concerned plaintiff's condition was the result of something more serious than pneumonia. After performing

additional tests, Dr. Stacy confirmed Phillips was suffering from bacterial endocarditis. Phillips' condition worsened and he was pronounced dead on September 28, 1998. All parties agree the cause of death was acute bacterial endocarditis.

B. Procedural History

Plaintiffs[2] sued Hillcrest Medical Center, Dr. Carolyn Cobb, and Emergency Physicians, Incorporated (later amended to Tulsa Emergency Physicians, Incorporated (TEP)). The suit related only to the evaluation, diagnosis, and treatment provided Phillips on September 23, 1998. Plaintiffs alleged defendants violated the Emergency Medical Treatment and Active Labor Act (EMTALA) and also brought a claim for wrongful death under Oklahoma medical malpractice law for failing to properly treat Phillips.

Prior to trial, the district court dismissed the EMTALA claim against Dr. Cobb and TEP. The remaining claims were presented to a jury. At the close of evidence, the district court sustained HMC's Rule 50 motion, holding no EMTALA claim existed as a matter of law, and sustained appellants' Rule 50 motion that Dr. Cobb was the agent of HMC.[3] The district court submitted the issue of medical malpractice/wrongful death to the jury and a verdict in favor of HMC was returned. Plaintiffs filed this appeal.

C. Summary of Issues on Appeal

On appeal, appellants raise four issues. Appellants allege the district court erred in (1) granting HMC's Rule 50 motion as to the EMTALA claim, (2) admitting allegations of Phillips' drug use, (3) excluding plaintiffs' expert testimony regarding the cause of bacterial endocarditis, and (4) refusing to allow cross-examination of HMC's nurse regarding Exhibit 25 and Exhibit 26.

II. ANALYSIS

A. EMTALA

Appellants argued at trial that HMC treated Phillips differently than similarly situated patients because he was alleged to be uninsured and that HMC's established procedures were not followed. The district court ruled no evidence of differential treatment was presented and, at most, the complained of conduct amounted to negligence. See Vol. II, pp. 844-45. At the invitation of the district court,[4] appellants are now pressing similar argument before this court.

1. Standard of Review

This court reviews the grant of judgment as a matter of law de novo, sitting in the same position as the trial court. See Tyler v. Re/Max Mountain States, Inc., 232 F.3d 808, 812 (10th Cir. 2000). Pursuant to Rule 50 of the Federal Rules of Civil Procedure, a trial judge may grant a motion for judgment as a matter of law if, after a party has been fully heard on an issue, there is no legally sufficient evidentiary basis for a reasonable jury to find for the party on that issue. See Tyler, 232 F.3d at 812; Finley v. United States, 82 F.3d 966, 968 (10th Cir. 1996). This court has read FRCP 50(a) to mean judgments as a matter of law may be granted "only if the evidence points but one way and is susceptible to no reasonable inferences which may support the opposing party's position." Finley, 82 F.3d at 968; see also Tyler, 232 F.3d at 812 (relying upon Reeves v. Sanderson Plumbing Prods., Inc., 530 U.S. 133 (2000)) . As such, the facts and all reasonable inferences from them are viewed in the light most favorable to the appellant. See Finley, 82 F.3d at 968.

2. Legal Framework

Congress enacted EMTALA in 1986 to address the problem of "dumping" patients in need of medical care but without health insurance. See Abercrombie v. Osteopathic Hosp. Founders Ass'n, 950 F.2d 676, 680 (10th Cir. 1991); Stevison v. Enid

Health Sys's, 920 F.2d 710, 713 (10th Cir. 1990). Though originally intended to cure the evil of dumping patients who could not pay for services, the rights guaranteed under EMTALA apply equally to all individuals whether or not they are insured. See Collins v. DePaul Hosp., 963 F.2d 303, 308 (10th Cir. 1992) (stating EMTALA also applies to those who are covered by health insurance); see also Summers v. Baptist Med. Ctr. Arkadelphia, 91 F.3d 1132, 1137 (8th Cir. 1996) (en banc) (stating the statute literally applies to "any individual" so a lack of indigency or uninsured status does not defeat an EMTALA claim). Thus, whether Phillips was or was not actually covered by his employer's insurance plan is of no consequence to the resolution of this issue on appeal.

Under EMTALA, a participating hospital[5] has two primary obligations. See Ingram v. Muskogee Reg'l Med. Ctr., 235 F.3d 550, 551 (10th Cir. 2000). First, the hospital must conduct an initial medical examination to determine whether the patient is suffering from an emergency medical condition. See Abercrombie, 950 F.2d at 680. The second obligation requires the hospital, if an emergency medical condition exists, to stabilize the patient before transporting him or her elsewhere. See Urban v. King, 43 F.3d 523, 525 (10th Cir. 1994). To ensure compliance with these obligations, Congress created a private cause of action. See 42 U.S.C. § 1395dd(d); Repp v. Anadarko Mun. Hosp., 43 F.3d 519, 521-22 (10th Cir. 1994). Appellants' only claim under EMTALA is for an alleged failure to provide an appropriate screening as required by section 1395dd(a).

Pursuant to section 1395dd(a), HMC was required to conduct an "appropriate medical screening examination . . . to determine whether or not an emergency medical condition . . . exists." 42 U.S.C. § 1395dd(a).[6] This court has stated that whether a given hospital has performed an "appropriate medical screening examination," as defined by EMTALA, varies with the unique capabilities of the specific hospital. See Repp, 43 F.3d at 522. Further, we give appropriate deference to the existing screening

procedures utilized by the hospital, because it, not a reviewing court, is in a superior position to determine its own capabilities and limitations. See id. at 522 & n.4 ("A court should ask only whether the hospital adhered to its own procedures, not whether the procedures were adequate if followed."). Based upon those pre-existing procedures,[7] adopted and employed by a hospital, the Repp court held EMTALA's screening requirement is violated "when it does not follow its own standard procedures." See id. at 522.

The underlying principle behind section 1395dd(a) is to ensure all patients, regardless of their perceived ability or inability to pay for medical care, are given consistent attention. EMTALA's requirement of an "appropriate screening examination" undeniably requires HMC to "apply uniform screening procedures to all individuals coming to the emergency room." Vickers v. Nash Gen. Hosp. Inc., 78 F.3d 139, 143 (4th Cir. 1996) (stating uniform treatment for all patients, regardless of ability to pay, is considered "the linchpin of an EMTALA claim"). While this court has never expressly described the obligation under EMTALA in terms of uniform or disparate treatment, several of our sister circuits, as well as numerous district courts within this circuit, have. See id.; Marshall v. East Carroll Parish Hosp. Serv. Dist., 134 F.3d 319, 323 (5th Cir. 1998); Summers, 91 F.3d at 1138; Holcomb v. Monahan, 30 F.3d 116, 117 (11th Cir. 1994); Scott v. Hutchinson Hosp., 959 F. Supp. 1351, 1357 (D. Kan. 1997) ("A hospital satisfies the requirements of § 1395dd(a) if its standard screening procedure is applied uniformly to all patients in similar medical circumstances."); Tank v. Chronister, 941 F. Supp. 969, 972 (D. Kan. 1996) (quoting Vickers, 78 F.3d at 144) ("EMTALA is implicated only when individuals who are perceived to have the same medical condition receive disparate treatment . . . ."). To the extent it was unclear before, this court holds, as it implicitly did in Repp, a hospital's obligation under EMTALA is measured by whether it treats every patient perceived to have the same medical condition in the same manner. "Disparate treatment" is simply another term for describing or measuring a hospital's

duty to abide by its established procedures. Unless each patient, regardless of perceived ability or inability to pay, is treated in a uniform manner in accordance with the existing procedures, EMTALA liability attaches. See Repp, 43 F.3d at 522.

3. Appellants' Claims

Appellants argued to the district court, as they have here, that evidence of a bias towards those who are uninsured is sufficient to state an EMTALA claim. They point to the testimony of Mike Lulka regarding the initial intake procedures HMC undertook and attempt to extrapolate an intolerance towards those perceived to be uninsured.[8] They also look for support in Christina Daczewitz's testimony that she saw, some time after Phillips' death, a notation of "no insurance" on Phillips' medical records at HMC. Appellants' repeated attempts to introduce evidence regarding HMC's motives are irrelevant to whether Phillips was treated in a manner consistent with HMC's existing procedures. This circuit, like many others, does not require any particular motive for EMTALA liability to attach. See Repp, 43 F.3d at 522 n.5 (stating EMTALA imposes strict liability). EMTALA looks only at the participating hospital's actions, not motives. See Stevison, 920 F.2d at 713 ("We construe [section 1395dd(a)] as imposing a strict liability standard subject to those defenses available in the act."); see also Roberts v. Galen of Virginia, 525 U.S. 249, 252 (1999) (stating the Sixth Circuit's requirement of an improper motive is in conflict with several circuits, including the First, Fourth, Eighth, and D.C. Circuit). While testimony regarding a hospital's knowledge of a patient's lack of insurance coverage may be relevant to explain a failure to abide by established procedures, it alone does not establish a violation of EMTALA's requirement of uniform treatment.

Moving to the crux of their EMTALA claim, appellants attempted to identify certain HMC policies they claim were not followed. During the Rule 50 colloquy, the district court asked appellants to point to the evidence adduced in support of the EMTALA claim. See Vol. II, p. 827. As they have before this

court, appellants pointed to Exhibit 47 (Vol. IV) and an unidentified discharge policy, claiming various aspects of these policies were not followed. The district court repeatedly implored appellants' counsel to describe the evidence showing that HMC failed to screen and evaluate Phillips' condition. In the interest of brevity, it is sufficient to say appellants' counsel reluctantly conceded HMC, either through Nurse Cue and/or Dr. Cobb, did in fact make a determination as to Phillips' condition with respect to each and every allegation of failure to abide by existing policy requirements. See Vol. II, p 829, ln. 19-20; Id. at p. 830, ln. 11 - p. 831, ln. 4; Id. at p. 831, ln. 5 - p. 832, ln. 4; Id. at p. 843, ln. 11 - p. 844, ln. 12. Based upon these admissions and in reliance upon Repp and Tank v. Chronister, 941 F. Supp. 969 (D. Kan. 1996), the district court stated that so long as HMC performed a medical screening examination, consistent with its policies and in an effort to discern whether Phillips was suffering from an emergency medical condition, EMTALA was satisfied.

Appellants' argument brings into focus the uneasy intersection between EMTALA and state law medical negligence claims. They argue HMC staff failed to appropriately identify and/or appreciate the gravity of Phillips' condition. In other words, while they concede HMC technically complied with their pre-existing standards, the practical effect was an inadequate examination. EMTALA was not, however, designed for such a claim. Though it created a new cause of action, we have consistently recognized EMTALA's provisions have only a limited reach and purpose. See Ingram, 235 F.3d at 552 (citing several cases for the proposition that EMTALA's limited purpose was to eliminate "patient-dumping").

EMTALA does not set a federal standard of care or replace pre-existing state medical negligence laws. See, e.g., Repp v. Anadarko Mun. Hosp., 43 F.3d 519, 522 (10th Cir. 1994); Power v. Arlington Hosp. Ass'n, 42 F.3d 851, 856 (4th Cir. 1994) ("EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or

to provide a federal remedy for misdiagnosis or medical negligence."). While providing a guaranty for an "appropriate medical screening," EMTALA, unlike traditional state negligence or malpractice law, does not provide a remedy for an inadequate or inaccurate diagnosis. See Vickers, 78 F.3d at 142. For example, in Collins v. DePaul Hospital, we stated the purpose of section 1395dd(a)'s screening examination "is to determine whether an 'emergency medical condition exists.' Nothing more, nothing less." Collins, 963 F.2d 303, 306-07 (10th Cir. 1992) (footnote omitted). Thus, while appellants were allowed to go to the jury with their medical malpractice claim for the alleged conduct of HMC's staff,[9] the district court was, as a matter of law, correct in stating no evidence of an EMTALA claim was presented.

B. Drug Use

In addition to the EMTALA claim, appellants alleged Dr. Cobb and HMC violated the standard of care in the treatment of Phillips. As an affirmative defense, Dr. Cobb and HMC responded Phillips was at fault, invoking Oklahoma's comparative negligence defense, for failing to notify them of his prior drug use. HMC claimed this failure to provide relevant medical information contributed to any negligent care it may have provided.

Prior to trial, appellants moved to exclude any and all evidence of Phillips' alleged drug use. The district court denied this request and allowed testimony that Phillips had used "street drugs" and failed to inform Dr. Cobb of this information when he sought treatment at HMC. The court ruled the evidence was admissible to support HMC's defense of comparative negligence. On appeal, appellants argue that the evidence was irrelevant and unduly prejudicial.

1. Standard of Review

Though appellants moved, in limine, to exclude evidence of drug testimony, they failed to renew their objection at trial. HMC admits this has sufficiently preserved the issue for appellate review. See United States v. Mejia-Alarcon, 995 F.2d 982, 986 (10th Cir. 1993) (stating a motion in limine may preserve the ruling for review when the issue (1) has been fairly presented to the trial court, (2) is the type of issue that can be finally decided in a pretrial hearing, and (3) is ruled upon without equivocation). By presenting the issue to the district court and receiving a definitive ruling, appellants were entitled to rely upon the ruling as the law of the case and to have this court review the decision under an abuse of discretion standard. See id. Under this standard, we will not reverse unless there has been "a distinct showing it was based on a clearly erroneous finding of fact or an erroneous conclusion of law or manifests a clear error of judgment." United States v. Mitchell, 113 F.3d 1528, 1531 (10th Cir. 1997) (internal quotations omitted).

2. Relevance

In Oklahoma, evidence of a patient's failure to provide an accurate medical history is relevant to the defense of contributory negligence in a medical malpractice claim. See Okla. Stat. tit. 23, §§ 13, 14; Graham v. Keuchel, 847 P.2d 342, 358 & n.78 (Okla. 1993) (stating patient's failure to inform the medical staff about her rare blood type may be considered by the jury as an indication of her contributory negligence). In Bointy-Tsotigh v. United States, for example, the plaintiff claimed "[p]hysicians at the defendant facilities did not perform the appropriate diagnostic tests to determine the source" of plaintiff's medical condition. Bointy-Tsotigh, 953 F. Supp. 358, 362 (W.D. Okla. 1996) Despite the defendants' failure to adequately test (or perform "diagnostic tests"), the court reduced plaintiff's damages because she failed to give her accurate medical history to the treating physicians. See id. at 362 (applying Oklahoma law). Based upon Oklahoma law, there can be little doubt Phillips' failure to inform HMC and/or Dr. Cobb

of his medical history was relevant and necessary to the defense of contributory negligence.[10]

3. Unfair Prejudice

Even assuming Phillips' failure to inform HMC of his prior drug use was relevant, appellants claim the district court erred because evidence of Phillips' drug use was unfairly prejudicial. Pursuant to Rule 403, the district court must determine whether the admission of relevant evidence would cause unfair prejudice. See Fed. R. Evid. 403. Due to the district court's superior position to gauge the testimony's prejudicial impact in light of the evidence presented throughout trial and the jurors' perception of the case as a whole, we give the district court's determination a large degree of deference. See, e.g., Joseph v. Terminix Int'l Co., 17 F.3d 1282, 1284 (10th Cir. 1994).

Under Rule 403, relevant evidence may be excluded "if its probative value is substantially outweighed by the danger of unfair prejudice." Fed. R. Evid. 403. According to the literal language of the rule, ordinary prejudice alone is insufficient to exclude relevant evidence. The prejudice must be unfair, such that we may conclude the jurors made their decision based not upon the evidence presented but upon their confusion, passion, or emotion. See, e.g., Stump v. Gates, 211 F.3d 527, 534 (10th Cir. 2000); see also Securities and Exchange Comm'n v. Peters, 978 F.2d 1162, 1171 (10th Cir. 1992) (noting the unfair prejudice must "substantially outweigh" the probative value).

Based upon a review of the proceedings appellants have identified as most egregious, we are unable to conclude any unfair prejudice occurred. The testimony from HMC and Dr. Cobb's expert simply noted the obvious drug use is an important indicator of a patient's physical condition and is crucial to determining whether to undertake additional testing. See Vol. II, p. 945.[11] While plaintiffs would have preferred evidence of Phillips' drug use not be presented to the jury, simple prejudice alone is insufficient to warrant exclusion. See

Peters, 978 F.2d at 1171 (noting almost all evidence, in the eyes of one party or the other, will be perceived as prejudicial).

C. Causation Testimony

Appellants next contend the district court erroneously excluded testimony of their expert, Dr. Benjamin E. Zola. Dr. Zola apparently would have testified that Phillips' alleged drug use did not cause bacterial endocarditis. The district court, however, ruled that evidence of what caused plaintiff's fatal condition was not at issue. See Vol. II, p. 755-56. The court stated the issue was whether Dr. Cobb negligently treated Phillips on September 23, 1998 and whether Phillips contributed, by withholding pertinent health information, to the alleged negligent care. See id. As such, what actually caused bacterial endocarditis was irrelevant to whether Dr. Cobb's treatment fell below the recognized standard of care.

1. Standard of Review

Ordinarily, this court would review the exclusion of expert testimony under the standards set forth in Daubert v. Merrell Dow Pharmaceuticals, Incorporated, 509 U.S. 579, 589 (1993). See, e.g., Hynes v. Energy West, 211 F.3d 1193,1202 (10th Cir. 2000) (citing Kumho Tire Co. v. Carmichael, 526 U.S. 137, 152 (1999)). Here, however, the district court did not exclude Dr. Zola's testimony based upon the merits of his expert opinion but rather because the proffered testimony was irrelevant to the issue at hand. This court reviews rulings excluding testimony under an abuse of discretion standard. See Dodoo v. Seagate Tech., Inc., 235 F.3d 522, 528 (10th Cir. 2000). "We will not overturn the trial court unless it has made 'an arbitrary, capricious, whimsical, or manifestly unreasonable judgment[.]'" Id. (citing Woodworker's Supply, Inc. v. Principal Mut. Life Ins. Co., 170 F.3d 985, 992 (10th Cir. 1999)).

2. Causation of Disease

Appellants made a proffer that Dr. Zola would testify that, based upon a reasonable degree of medical certainty, Phillips' drug use did not cause bacterial endocarditis. See Vol. II, p. 753-55. This testimony was necessary, appellants argue, to rebut arguments or evidence that HMC or Dr. Cobb might present to the effect Phillips caused his own death. The district court stated that the cause of Phillips' bacterial endocarditis was irrelevant to the negligence claim at issue and that Phillips' use of drugs was relevant only to the extent that he failed to inform Dr. Cobb of a pertinent medical condition. See id. at 755. While counsel for HMC and Dr. Cobb were free to argue Phillips withheld pertinent information, the district court rule that "if [counsel for HMC or Dr. Cobb] start even for a moment suggesting that the cause of death was drug use, then there will be serious old testament stuff." Id.

Because appellant has failed to indicate any events contrary to this ruling actually occurred, we are assured all arguments fell well within this ruling. Without evidence alleging Phillips caused his own death, appellants' sole justification for Dr. Zola's testimony vanishes. Accordingly, we hold the district court's decision fell well within his wide discretion. Furthermore, while it may have been appropriate to offer a limiting instruction to the jury, there is no indication appellants requested one. Given appellants' failure, we can not say plain error occurred. See Gilbert v. Cosco Inc., 989 F.2d 399, 404 (10th Cir. 1993); see also United States v. Pedraza, 27 F.3d 1515, 1526 (10th Cir. 1994) (stating the failure to seek a limiting instruction, in a criminal case, may be the result of a tactical decision).

D. Cross-examination

In their fourth and final point, appellants allege evidence of disparate treatment (applicable only to the EMTALA claim) would have been shown if the district court had allowed them to cross-examine HMC's triage nurse, Lugenia Cue, with Exhibits 25 and 26. These exhibits were summaries, prepared by HMC's counsel at the request of appellants, indicating the number of

patients admitted to the emergency room (Exhibit 25) and the minor care area of HMC (Exhibit 26) on September 28, 1998. See Vol. IV, Exs. 25 and 26. The information contained in these exhibits showed the time the unnamed patients were admitted and released, a one to two word description of their symptoms, and which side of the hospital they were sent to after initial "triaging." Upon consulting the record, it appears appellants sought to submit these two documents to the jury as definitive proof of differential treatment by HMC. See Vol. I, p. 370-77. The district court ruled this method was unduly confusing to the jurors but invited appellants to question Cue as to Phillips' condition and whether, as a general matter, more patients with those symptoms were triaged to the emergency room on that day or otherwise. See id. at pp. 375-78. Appellants then asked Cue whether she typically sent more people with chest pain to the minor side or to the emergency side, but when she responded she could make no categorical statement, the issue was pressed no further. See id. at 378.

1. Standard of Review

As an initial matter, the parties disagree as to what standard of review this court should use to analyze appellants' claim of error. HMC contends no offer of proof was made as to the content of these exhibits and therefore this court may review only for plain error. As we have stated before, "[e]rror may not be based on a ruling excluding evidence unless 'the substance of the evidence was made known to the court by offer [of proof] or was apparent from the context within which questions were asked.'" Inselman v. S & J Operating Co., 44 F.3d 894, 896 (10th Cir. 1995) (quoting Fed. R. Evid. 103(a)(2)); United States v. Janusz, 135 F.3d 1319, 1323 (10th Cir. 1998) (quoting Fed. R. Evid. 103(a)(2)). The purpose of this rule is obvious it allows the district court to make an informed evidentiary ruling and creates an adequate record for appellate review to determine whether the trial court's ruling was reversible error. See Inselman, 44 F.3d at 896.

In order to satisfy Rule 103(a)(2), we have held that "'merely telling the court the content of . . . proposed testimony' is not an offer of proof." Polys v. Trans-Colorado Airlines, Inc., 941 F.2d 1404, 1407 (10th Cir. 1991) (quoting Gates v. United States, 707 F.2d 1141, 1145 (10th Cir. 1983)). Rather, the proponent of the excluded evidence must explain what he expects the evidence to show and the grounds for which he believes the evidence is admissible. See Polys, 941 F.2d at 1407. If appellants have failed to meet this hurdle, this court can reverse the district court's ruling only if there was plain error that affected appellants' substantial rights. See id. at 1408; Fed. R. Evid. 103(d). The plain error exception in civil cases "has been limited to errors which seriously affect the fairness, integrity or public reputation of judicial proceedings." Polys, 941 F.2d at 1408 (internal quotation omitted). It is an extraordinary, nearly insurmountable burden. See id. at 1408 n.5 (collecting cases).

Based upon a review of the record, appellants have sufficiently preserved this issue for appeal. Specifically, the exhibits were identified, their contents and origins discussed, and argument as to their admissibility was made. See Vol. I, pp. 369-76. We hold this more than sufficiently met the demands of Polys. As such, appellants' allegation of error will be reviewed under the less stringent abuse of discretion standard. See Polys, 941 F.2d at 1407. Even under this more lenient standard, however, appellants' argument is unavailing.

2. Exclusion of Testimony

The district court's rationale for excluding the exhibits is that they were rough summaries made by HMC's counsel, were utterly ambiguous, and, without more information, would be "fundamentally misleading." Vol. I., p. 374. Though not expressed, it appears the court relied upon Rule 403 and determined the evidence, in the form of exhibits 25 and 26, would have painted a distorted picture. In order to allow the alleged differential treatment evidence to be presented to the jury, however, the district court provided a sufficiently effective

alternative method.[12] While the district court excluded arguably relevant evidence, it was not an abuse of discretion, especially considering the viable and effective alternatives discussed and agreed to by counsel. See Deters v. Equifax Credit Information Servs. Inc., 202 F.3d 1262, 1274 (2000).

III. CONCLUSION

After a thorough review and analysis of all issues fairly presented, we AFFIRM.

FOOTNOTES

Click footnote number to return to corresponding location in the text.

* Honorable Monti L. Belot, United States District Judge for the District of Kansas, sitting by designation.

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1. When patients arrive at HMC, hospital personnel perform a "triage." Triage is a procedure, first used by military hospitals, to perform an initial assessment of a patient's symptoms in order to direct the patient to the area of care commensurate with his condition. See American Heritage Dictionary 1908 (3d ed. 1992).

2. Plaintiffs include Phillips' surviving daughter (Crystal Star Phillips), his Estate (the Estate of Martin Shane Phillips), his father (Fred Phillips, Jr.), and the mother of his daughter (Minnie Christina Daczewitz).

3. As such, Dr. Cobb is no longer a party to this case.

[4] The court stated to appellants' counsel "you certainly can amplify [your argument] many pages over in Denver, but you've certainly got a record here." Vol. II, p. 852, lns. 3-4.

[5] The parties agree HMC is a participating hospital and is therefore covered by EMTALA's requirements. See 42 U.S.C. § 1395dd(e)(2).

[6] 42 U.S.C. section 1395dd(a) reads as follows:

Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

[7] When a procedure has not been established by a participating hospital, the inquiry is somewhat different. See, e.g., Power v. Arlington Hosp. Ass'n, 42 F.3d 851, 858 (4th Cir. 1994); Griffith v. Mt. Carmel Med. Ctr., 831 F. Supp. 1532, 1539-40 (D. Kan. 1993). Such is not the case here as the parties agree a policy was in place at HMC.

[8] Interestingly, however, Lulka further stated the fact that Phillips did not have on his person the insurance card was not a problem and did not appear to affect the care of Phillips.

[9] They did and the jury returned a verdict in favor of HMC and Dr. Cobb.

[10] Appellants have attempted to avoid this result by claiming their negligence claim was based upon Dr. Cobb's failure to "test," not "diagnose," Phillips. It is unclear to this court what, if any, significance this alleged distinction would make to the relevance of Phillips' withholding pertinent medical information from his treating physicians. Because appellants have failed to support this distinction with any authority, legal or otherwise, we need not consider it. See, e.g., Pelfresne v. Village of Williams Bay, 917 F.2d 1017, 1023 (7th Cir. 1990) ("A litigant who fails to press a point by supporting it with pertinent authority, or by showing why it is sound despite a lack of supporting authority or in the face of contrary authority, forfeits the point. [The court] will not do his research for him."); Capps v. Cowley, 63 F.3d 982, 984 (10th Cir. 1995) (citing Pelfresne); Robinson v. Tenantry (In re Robinson), 987 F.2d 665, 668 (10th Cir. 1993); Phillips v. Calhoun, 956 F.2d 949, 953 (10th Cir. 1992) (citing Pelfresne).

[11] Specifically, the identified portion of the record reads:

> 1. All right. Before we move on, I want to go back to bacterial endocarditis and just ask you for diagnostic purposes is it important for you, the clinician, to know whether or not the patient is using street drugs?
>
> 1. I think it is. And much as I indicated earlier in terms of the historic or the setting, the use of street drugs raises your suspicion for infectious processes with particular regard to the heart and much like if you have a history of abnormal heart valves or previous heart surgery.

Vol. II, p. 945, lns. 8-16. In addition, counsel for Dr. Cobb, in opening statement, claimed drug use was relevant to the case because, "for diagnostic purposes the clinician needs to know that because it's well known that [the use of] street drugs is a well known predisposing factor for various infections including bacterial endocarditis, and they need to know that." Vol. I, p. 56, lns. 8-13.

[12] The colloquy between appellants counsel and the district court went as follows:
Court: Right. So the question I mean, you can ask her why it is that she chose, in the face of chest pain, to send him to minor care. And you can even ask her if in more circumstances than not, chest pain goes to the emergency room. But your goal here is to talk about what she saw and heard and what decision she made and why she made them, and whether or not those decisions in the normal course were different than what she normally does.
Counsel: Is Your Honor saying I can ask her typically do more people go to the emergency side with chest pain?
Court: Does she send more people to the emergency side.
Counsel: Yes sir.
Court: And what was it about this patient that caused her not to do that.
. . .
Court: [] The point is, is that with that the one word entry doesn't tell us anything about whether or not somebody should go to the minor care side or ER side; right?
Counsel: Well, I mean, I think that's something that the witness would certainly be able to explain. But I understand. With my objection noted, Your Honor, I understand the court's ruling.
Court: No. I understand your objection. All Right.
Vol. I, pp. 375-76.

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

CRYSTAL STAR PHILLIPS, individually, And As next of kin to Martin Shane Phillips, on behalf of THE ESTATE OF MARTIN SHANE PHILLIPS, By and through her mother, legal guardian and next friend, MINNIE CHRISTINA DACZEWITZ and FRED MARTIN PHILLIPS JR., parent of Martin Shane Phillips the Plaintiffs, vs. HILLCREST MEDICAL CENTER, an Oklahoma corporation doing business in the State of Oklahoma, and CAROLYN COBB, a physician, and TULSA EMERGENCY PHYSICIANS, INC., an Oklahoma Corporation doing business in the State Of Oklahoma the Defendants.	)	FILED MAR 31 2000 Case No. 98-CV-829H(E)

REPORTERS TRANSCRIPT OF PROCEEDINGS

HAD ON DECEMBER 13, 1999 THROUGH DECEMBER 17, 1999

JURY TRIAL- VOLUME I-V

BEFORE THE HONORABLE SVEN ERIK HOLMES, Judge

motions, shall we? Shall we start --Mr. Paul, you are recognized, sir.

MR. PAUL Yes, sir. Your Honor, comes now the defendant Hillcrest Medical Center pursuant to Rule 50 of the Federal Rules of Civil Procedure and moves for a dismissal and/or a directed verdict for the following reasons:

Number one, we do not believe that the plaintiff has proven a case, even taking the evidence in the light most favorable to the plaintiff, that there has been a violation of EMTALA. Number two, we do not believe the plaintiff has proven, by taking the light -- the evidence in the light most favorable to the plaintiff that they have proven a case of negligence. And number three, and in the alternative, we also are moving for a directed verdict and a dismissal of any claims for punitive damages.

And with the Court's permission I can argue those three separately.

THE COURT All right. Let's take them. We have, I think, time to address them and we will put the plaintiffs to their evidence on each of these matters forthwith, but if you could briefly and then we will turn to the plaintiffs. Go ahead.

MR. PAUL Briefly make my arguments on each?

THE COURT Yes, if you could.

MR. PAUL Okay. In regards to EMTALA, it's my

understanding that the law requires that when patients come into the emergency room to request treatment, that they be given an appropriate medical screening. The courts have been very clear that what that means is that the medical screening process be applied uniformly to all patients who request treatment. It is not a subject, the medical screening, to inquire whether or not the medical screening was done appropriately, whether it was done correctly, just whether it applied to that particular plaintiff the same as it does to all plaintiffs. And I think the evidence in this case -- or all potential plaintiffs. I think the evidence in this case is very clear that Mr. Phillips was given the medical screening. He was seen by the triage nurse, he was then seen by a physician. The evidence is without dispute that that's the way it's done with all of the patients there. If the plaintiffs have some complaint about the diagnosis that was reached, that does not support a claim and a violation of EMTALA.

That in a nutshell, I believe, is our argument. I know that the plaintiffs were claiming something about the fact of this insurance card, but I think Mr. Lulka resolved any misunderstandings that the plaintiffs may have had on that subject because he was very clear in his testimony that they merely asked for the insurance card and they went on and got the rest of the information. There was no indication there that he would not be seen because he didn't have his insurance

card, and there's certainly no evidence from any of the other witnesses that his treatment in any way was different, his screening process was any different because of the fact that he did not have his insurance card. And I heard this testimony from Ms. Daczewitz of course for the first time this morning that there might have been some statement in the medical chart about no insurance when she went up there three weeks later, but that certainly had nothing to do with the situation that presented on September 23rd, 1998.

THE COURT: All right. On the EMTALA claim. All right. You are recognized, Mr. Toon, go ahead.

MR. TOON: Your Honor, we would respectfully request the Court deny the defendants' Rule 50 in that regard. In particular Mr. Paul indicated that the medical screening is supposed to be applied uniformly. In this case we believe that it was not, based on their own policies and procedures.

THE COURT: which ones are those, sir?

MR. TOON: In the particulars, Your Honor, there is regarding sending him to the minor side of the emergency room versus the emergency side of the emergency room. Additionally the issue --

THE COURT: Which policy are you talking about?

MR. TOON: In the triage manual, Your Honor.

THE COURT: All right. Is that the cardiac policy

MR. TOON: No, that's in Plaintiffs' Exhibit No. 47.

THE COURT: All right. Number D and I, for example?

MR. TOON: Yes, I believe so, sir. I think there's 0 in that also.

THE COURT: Okay. And the testimony -- the question of whether or not, as to Exhibit 47, whether or not under D, whether or not the patient does not appear acutely ill; right?

MR. TOON: Yes, sir.

THE COURT: Isn't that the issue there?

MR. TOON: Yes, sir.

THE COURT: And the testimony, the sole testimony was he did not appear acutely ill; right?

MR. TOON: Well, that's not entirely accurate. I think that's a factual issue, Your Honor, because Mr. Lulka in his testimony said that he had the sweats and he had the chills, so that's an issue about whether he did or not. Of course the people from Hillcrest indicated that he didn't appear that way, but Mr. Lulka testified, I believe, that was the way he looked like. It sounds like he was acutely ill.

THE COURT: Well, your own witness said that it was -- that may be a wrong assessment as to whether he was acutely ill, which would be a question of negligence. But the question is whether or not she made a determination as to whether or not he appeared acutely ill; right? Did he make that deter -- did she make that determination?

MR. TOON: Well, I think, Your Honor.

THE COURT: She might have made it wrong, but did she make that determination?

MR. TOON: Well, her testimony was that she felt he was not acutely ill, but --

THE COURT: That doesn't render him not looking acutely ill. But did she make had a determination of whether he appeared acutely ill?

MR. TOON: Her testimony was that he not. However, that still doesn't relieve them of EMTALA.

THE COURT: No, your missing my question.

MR. TOON: Okay.

THE COURT: There's difference between an EMTALA question and a negligence question.

MR. TOON: I agree.

THE COURT: Stay with me on the EMTALA question.

MR. TOON: Okay.

THE COURT: Did she undertake to make a determination of whether he appeared acutely ill?

MR. TOON: It seems like she did, yes, sir I recall.

THE COURT Okay. Now, with respect to I, there was also testimony on that; right?

MR. TOON: I need to grab Exhibit 47 in order to know.

THE COURT Okay. Didn't your witness address I, that is a 100 to 120 pulse; right? significantly abnormal vital

sign.

MR. TOON: Yes, sir.

THE COURT: Right? Did the triage nurse make a determination or undertake to make a determination as to whether she believed that was a significantly abnormal vital sign?

MR. TOON It is significantly abnormal based on their policies and --

THE COURT Did she undertake to make a determination as to whether or not that was a significantly abnormal vital sign?

MR. TOON I don't know if she undertook that or not, sir. I know that --

THE COURT She testified to it.

MR. TOON Well, she noted --

THE COURT She said she didn't believe it. She noted it and didn't believe that it was significantly abnormal; right?

MR. TOON Well, she testified, I believe that it was not, but at the time she didn't say whether she undertook at that time whether it was or not, from what I recall.

THE COURT Well --

MR. TOON And if she misses it that doesn't mean that she gets out.

THE COURT If she misses it, by your witness' own

testimony she may be exposed to malpractice but it is not an EMTALA question.

MR. TOON: I --

THE COURT: All right. Go ahead. What else?

MR. TOON: There is 0, regarding a person under 30 years old that presents with pleuritic type chest pain and is diaphoretic.

THE COURT: Right. Did she undertake to determine whether or not he was diaphoretic?

MR. TOON: I don't -- I think her testimony was that he was not. But that is a fact question --

THE COURT: Right. So she undertook to determine it. She might have been wrong; right? But she undertook to determine it, and we also know that because that's on the chart; isn't it? No sweats, no shortness of breath, no nausea. Right?

MR. TOON: That's Dr. Cobb. That's not the triage.

THE COURT: In the triage didn't she say on the stand that she undertook to determine whether or not he was sweating.

MR. TOON: She said that she recalled that he was not sweating.

THE COURT: Right.

MR. TOON: Right. But then she --

THE COURT: Okay. She might have been wrong. That's a fact issue as to whether or not she was wrong in that

determination, but if she undertakes to make that determination, if she gets it wrong then, then that's cognizable under state malpractice law, but it is not cognizable under EMTALA.

MR. TOON: I disagree, Your Honor.

THE COURT: Okay. Well.

MR. TOON: Did they provide --

THE COURT: Have you read, Mr. Toon, have you read Repp vs. Anadarko Municipal Hospital.

MR. TOON: It has been a little time, yes, sir, but I have.

THE COURT: Okay.

MR. TOON : And I don't recall the exact --

THE COURT: And Tank vs. Chronister --

MR. TOON: Your Honor --

THE COURT: -- United States District Court from the District of Kansas? It says "A claim alleging misdiagnosis remains a matter of state malpractice law."

MR. TOON: And I don't disagree with that, Your Honor.

THE COURT: Okay. So if it is cognizable as a malpractice claim and they undertook to that make that screening but did it wrongly, then it is a malpractice allegation, but not an EMTALA allegation; right?

MR. TOON: The question is did they provide him with an appropriate medical screening.

THE COURT: Right.

MR. TOON: Not did they try to but they never did provide it, because then they don't meet EMTALA.

THE COURT: Well, that's where you are just wrong. If they try to by virtue of complying with their procedures -- she complied with the procedures if she made a determination of whether or not he appeared to have the sweats. She complied with procedures because she made a determination that he didn't. Now, is that negligence? It's certainly is if he's sweating. But if she made that determination, then she's complied with the policies. You can't say she's violated the policies if she thought that there were no sweats; right?

MR. TOON: No, that's riot what the policy says. The policy is very clear and that states a person with chest pain under 30 that is diaphoretic is not appropriate --

THE COURT: I guess the use of the word sweats is confusing our colloquy here?

MR. TOON: No, it's confusing, Your Honor, but you're --

THE COURT: Could we use the word sweats rather than diaphoretic?

MR. TOON: If the Court wishes, yes, we will.

THE COURT: Okay. She said that he wasn't sweating; right?

MR. TOON: That's a question of fact. The policy --

THE COURT: But she made a determination that in her judgment he wasn't sweating.

MR. TOON: That doesn't relieve them, Your Honor, of not following the policy because she says he wasn't. He had --

THE COURT: But your witness said that if she made that determination that he wasn't sweating, then the policy wasn't violated that was your witness.

MR. TOON: You are referring to Dr. Zola? Dr. Zola --

THE COURT: Did you have another witness, medical witness that I missed up there.

MR. TOON: I wanted to make sure I was following the Court's reasoning, Your Honor. And Dr. Zola stated that if he did not have it, then that policy wouldn't have been violated; right? That's my understanding of his testimony.

THE COURT: Right. And she made a determination that he did not have it.

MR. TOON: It doesn't relieve them under their policy, Your Honor. Their policy says --

THE COURT: He said the policy wasn't violated. Did you miss --

MR. TOON: No.

THE COURT: -- the entire examination by Mr. Paul on These policy issues?

MR. TOON: He did not say that, Your Honor. What he said was that if he was not sweating.

THE COURT: Right. If he was not sweating.

MR. TOON: But that's a fact –

THE COURT: She testified that in her judgment he was sweating.

MR. TOON: That's a fact question.

THE COURT: So she undertook, she undertook to make that determination. That's what EMTALA requires. If she makes it wrong it's cognizable under State malpractice law, but if she undertook it, then it's no longer an EMTALA violation, if she didn't even undertake it then most certainly it's an EMTALA violation. All right?

Now, what are the other policies that you are pointing to, sir?

MR. TOON: Additionally, Your Honor, we feel he wasn't treated as a person similarly situated would have been treated. In regards to, Ms. Delsorbo testified that at the initial part of her examination that Plaintiffs' Exhibit 47 was in effect on September 23 of 1998, which is that triage manual and protocol. Under that triage manual and protocol then the employees of Hillcrest are to strongly encourage individuals based on insurance status. Now, she testified then that that part of the policy was not in effect at the time, but originally she did. So there is an issue for the jury to decide on whether they were following that policy or not.

THE COURT: What's the uncontroverted testimony about

his treatment, vis—a—vis insurance?

MR. TOON: I don't understand what your question is, Your Honor.

THE COURT: All right. You called a witness up here, spent a lot of money, a lot of our time since you didn't even know he was here, but we undertook to bring up a fellow from the Altus prison farm, because it's critically important from my view to hear from a witness live. All right?

MR. TOON: Yes.

THE COURT: I found him to be an extremely honest and reliable person and he told us that there was absolutely no problem occasioned by the insurance.

MR. TOON: Your Honor, maybe I wasn't listening to that part. I --

THE COURT: What did he say about the insurance, Mr. Toon?

MR. TOON: I don't even recall specifically what he said, or generally what he said about the insurance. Mr. Copeland had that witness and you might be able to ask him. But --

THE COURT: So only Mr. Copeland listens during the cross—examine of Mr. Paul? Mr. Paul was quite clear, did he say that he was treated nicely and kindly and courteously?

MR. TOON: I know he said they were courteous, yes

THE COURT: Okay. Did he say that they presented the

issue for the insurance card?

MR. TOON: Yes.

THE COURT: Did he say that was no big deal?

MR. TOON: I don't know if he used the words "no big deal" or not, sir.

THE COURT: Was it no big deal? Was the testimony precisely "no big deal"?

MR. TOON: That may have been.

THE COURT: Mr. Copeland, is that what the testimony was, sir?

MR. COPELAND: Your Honor, I don't recall that being the testimony of Mr. Lulka, but according to what the Court --

THE COURT: He said it occasioned no big deal; right? He said was there a problem with the insurance? No, I gave them the card. We said here's the number. They said fine. Anything after that on insurance? No. Right? Isn't that what the testimony was?

MR. COPELAND: That's somewhat of what the testimony was, I believe.

THE COURT: I mean, was there anything, was there any indication in Mr. Lulka's testimony that there was any hesitation, recalcitrance, obstinance, unpleasantness, anything associated whatsoever with insurance?

MR. COPELAND: The issue --

THE COURT: That's a yes or no question, sir.

MR. COPELAND: If I may explain after I answer, yes, that's somewhat.

THE COURT: Was there any such issue, sir?

MR. COPELAND: There was no issue of him saying that they were fussy. If that's a proper paraphrase.

THE COURT: But, I mean, was there any indication that they felt some reaction to his not having insurance or having his card there? Was there any indication that that caused any kind of delay in the treatment?

MR. COPELAND: He said that they had to go through an explanation and that he did have the insurance.

THE COURT: Right. And then after explanation was given --

MR. COPELAND: Right.

THE COURT: As in, I don't have my card but I work here, and here's a number you can call. Right?

MR. COPELAND: Right.

THE COURT: Was there anything after that that caused any kind of hesitation, eyebrows raising, even somebody -- right? Isn't it at that point he said no, nothing after that. Right?

MR. COPELAND: That's generally speaking, yes.

THE COURT: All right. So where is the insurance part?

MR. COPELAND: Your Honor, the focus is not the

that they reacted to the fact.

THE COURT: The focus is the fact, Mr. Copeland, that's why I brought him here. Okay. Not so that you could have some talk about what somebody said to somebody and put them on. I want the gut who was here. So we've got one guy who was here and we brought him here and he could have made your case or he could have not made your case, I care not at all. I care about what the evidence shows. He was the guy who was there. He told us absolutely and honestly that there was no issue presented by insurance whatsoever. Whatsoever. You can review that testimony from here to Utica Avenue and back.

MR. COPELAND: But that is not the relevant part of his testimony. The Court is focusing on that and that's not the relevant part.

THE COURT: Well, I'm focusing on whether or not there was any indication anywhere at the time of the treatment that there was some problem presented by insurance.

MR. COPELAND: Obviously there was, Your Honor, if we can look at the case as a whole and not isolate one particular area.

THE COURT: Isolate. You have somebody who is an eyewitness to a murder you want to look at the case as a whole but don't talk to the eyewitness. I like to stay with the eyewitness.

MR. COPELAND: Well, first of all, I would also like

to take issue with the Court in regard to the Court stating that whenever Mike Lulka was on the stand, and he went back through the double doors and he stated that he believed he had been seen by someone when Martin Phillips was laying on the table curled up. We did not believe that it would be appropriate for the Court to not to allow the issue to go before the jury and let the jury decide was his testimony more credible at the time earlier in the event when he took his deposition --

THE COURT: Was it more credible after you visited him in county, you visited him in Vinita, you had 50 phone calls from Ms. Daczewitz, is it more credible? How many times did you visit him in Vinita?

MR. COPELAND: I was only there one time.

THE COURT: So you are saying the lawyers have only visited him one time.

MR. COPELAND: I'm sorry, Your Honor. I was there one time a couple days before the deposition to find out what the facts were and then we had the deposition. In his deposition he stated very clearly that at the time that he was back behind the double doors a nurse was there beside him.

THE COURT: Uh-huh.

MR. COPELAND: Martin Phillips was curled up on the table. He talked to Martin Phillips. Martin Phillips stated and I am -- I'm -- if you want to call rehabilitation or if you

want to call impeachment of my own witness.

THE COURT: Rehabilitation by saying he's lying? That's an interesting use of the word.

MR. COPELAND: Your Honor, all I'm saying is that he had previous testimony that came into evidence and that previous testimony also was under oath just as he was here today, and the jury has the right to hear that. But --

THE COURT: But we don't dispute the question that he -- let's stay on the insurance for a moment because we're going to handle this EMTALA claim.

MR. COPELAND: Sure.

THE COURT: We don't dispute that he occasioned absolutely no problems related to the insurance; right?

MR. COPELAND: Now, say that question so I make sure I'm answering clearly to the Court. I need to understand that question.

THE COURT: He testified under oath that the fact that Mr. Phillips didn't have his insurance card occasioned no problem.

MR. COPELAND: He stated he had to explain. But that's --

THE COURT: Okay. Beyond merely saying the words I don't have the card

MR. COPELAND: Right.

THE COURT: -- was there any problem whatsoever

associated with insurance?

MR. COPELAND: It depends on whether explaining is a problem in the eyes of the Court.

THE COURT: Is there anything beyond that, sir?

MR. COPELAND: In just that area of testimony, no.

THE COURT: Okay. And he was the person there; right?

MR. COPELAND: He was the person there. But --

THE COURT: Okay.

MR. COPELAND: But, Your Honor, they don't have to -- under EMTALA all they have to do is treat him differently. It's not that we as the plaintiffs have to prove that they in fact turned him away for no insurance.

THE COURT: Okay. What other policies -- well, there's no indication they treated him differently as a result of insurance because asking him to -- I don't have my card and they have to explain, that's not treating him differently.

MR. COPELAND: I --

THE COURT: Everybody -- are you saying that you put on evidence that said that other people don't present with insurance but they don't even have to say anything?

MR. COPELAND: No, Your Honor, all --

THE COURT: Okay. So you would stipulate that asking something about the insurance probably occurs when they say where's you're insurance? I don't have it, but I do, I am

covered. Right? We know from the records that they put down that they could call. Right?

MR. COPELAND: Yes, Your Honor, but I would like to be able to have the opportunity to state the case if the Court is getting ready to conclude the EMTALA claim.

THE COURT: Well, I'jn going to finish up with what other policies that were alleged to have been violated here. Right?

MR. COPELAND: Right.

THE COURT: Okay. What are the other policies?

MR. COPELAND: There's a policy, Your Honor, that is in evidence that prior to discharge, a patient is to be reassessed. Ms. Petty testified on her own testimony and said she never reassessed him. And as a direct --

THE COURT: And Dr. Cobb testified that she did reassess him.

MR. COPELAND: No, Your Honor. She testified that she looked at him but she testified she did not do her own independent blood pressure she relied on the triage statement. She did not do a blood pressure. A blood pressure is a vital sign and under the vital signs policy they are required to reassess this individual every 30 minutes according to the testimony of Dr. Zola according to the plain language of that policy. If a person has tachycardia which is between 100 and 120 and he said there's a little ambiguity in it as to whether

the 120 goes beyond 120.

THE COURT: She testified that she listened to his pulse. Now, it may be that listening to the pulse and after years and years of experience you can still make a mistake and therefore be cognizable in malpractice law, but if she undertook to make the determination as to the vital signs then it's not an EMTALA violation. It may be a malpractice violation.

MR. COPELAND: Okay. This is where the plaintiffs adamantly take issue with the Court that the Court is, we believe is making a wrong conclusion under the law, if we could explain.

THE COURT: All right. Have you read Repp vs. Anadarko Municipal Hospital.

MR. COPELAND: Your Honor, I have read that in the past and that is in our trial brief. But the point, Your Honor, is that it's very clear and it's in our trial brief, is that they don't get to get out of an EMTALA claim by coming up here and giving testimony to explain away what they do. In other words, there would never be an EMTALA claim that could ever be brought in a court of law that could be sufficient if a witness can set get up and say, oh, I undertook to do that, oh, I undertook to do this. If they got up, Your Honor, and in their own --

THE COURT: If the uncontroverted evidence -- I beg to

differ, sir. If the uncontroverted evidence establishes that in fact they undertook to do all of those things, then in fact there wouldn't be an EMTALA claim because EMTALA wants the undertaking, it doesn't necessarily want it to be done in accordance with the standard of care. To the extent that it is not it is cognizable in malpractice law. But the undertaking is what this is all about. You can't report to a hospital and be dumped, that is nobody undertook, it's an undertaking statute. The notion that that isn't what EMTALA is all about just simply is inconsistent with the law. Now, if they made every undertaking and made a hash out of it, there may be a malpractice claim but that is not an EMTALA claim. Furthermore, it is clear beyond any dispute that there is nothing about insurance from Mr. Lulka, who was there and testified about it, that that caused in any way any differential treatment. What -- to what do you look, sir, that indicates any differential in treatment occasioned by insurance?

MR. COPELAND: Occasioned by insurance, you heard the testimony of Minnie Christina Daczewitz who saw the no insurance which, Your Honor, if the jury is to look at that fact that that document disappeared, then all of a sudden the motive of turning away somebody for no insurance comes into play.

THE COURT: Right. But we had somebody there to see

if they were turned away from insurance and he said they weren't. So let's look at the result, not the motive.

MR. COPELAND: Your Honor, he's not --

THE COURT: We all could have a motive to do mayhem to somebody, it doesn't mean that we're culpable because we didn't do the act. Right? Let's talk act. What indicia of the act of treating him differently as a result of a failure to have insurance are you pointing to in this record?

MR. COPELAND: Your Honor --

THE COURT: Do you have any evidence at all?

MR. COPELAND: It's in the medical records. It's in the medical records.

THE COURT: What is that, sir?

MR. COPELAND: Your Honor, there's a stamp that says OU Medical Clinic, which is a place that they refer patients to that do not have insurance. And there is a follow-up request by Barbara Petty written in the Barbara Petty medical record that says go to the OU Medical Clinic. Your Honor, that is the place where they have-- they're sent. That's a place where they send people for no insurance.

THE COURT: And that was the testimony of who were you pointing to, sir?

MR. COPELAND: Your Honor, you are talking about --

THE COURT: The trial? The thing we have been doing for three days. The record of the trial.

MR. COPELAND: Right.

THE COURT: Where is it that there's any evidence whatsoever that there was an act taken as a result of not having an insurance card at the time of presentation.

MR. COPELAND: May I answer this question, Your Honor, after I explain what the plaintiffs' theory of the case is.

THE COURT: Well, we're in a Rule 50 motion. The question is whether or not under the applicable legal standard of Rule 50 you have made out a claim under EMTALA. EMTALA not just applying to the Repp vs. Anadarko but also Tank vs. Chronister by Judge Martin, a 1996 case at 941 F. Supp. 969 that goes into great detail about describing distinctions between malpractice and EMTALA violations.

In particular looking at the testimony of your own expert on cross --examination by Mr. Paul that went through every single violation and made clear that there was no evidence anywhere insofar as those violations, that if there was an undertaking and they got it wrong, then there was no violation. And he so stated.

Furthermore, with respect to the question of insurance, I'm going to ask you one last time, and I assume by your silence that you concede, that there is nothing in this record anywhere that indicates that they took any action based upon his failure to have his insurance card on that day.

MR. COPELAND: Your Honor, the very—

THE COURT: And in fact to the contrary Mr. Lulka said to the contrary. Now, is there anything that I have missed in this trial testimony, sir?

MR. COPELAND: Your Honor, there's the question of fact in the triage manual where they said they strongly encourage people that do not have insurance that are categorized in triage Category III, which this patient was, to go seek some other place. Strongly encourage, that was the testimony. Now the issue that Mr. Toon had brought before --

THE COURT: That wasn't testimony of fact. It wasn't a fact of how they treated this patient. We're talking about this patient, sir.

MR. COPELAND: Your Honor, this patient was in triage Category III. Clearly, clearly undisputed fact.

THE COURT: Right.

MR. COPELAND: Triage Category III.

THE COURT: And how did he get there?

MR. COPELAND: He came into the emergency room.

THE COURT: Right.

MR. COPELAND: And Lugenia Cue mistriaged him and put him into Category III. Our argument, Your Honor, is that they did this because of no insurance. They cannot avoid an EMTALA violation by merely miscategorizinq someone on purpose. That is --

THE COURT Right. And if there was any indication in

this record that they had done something because of the insurance, any nexus whatsoever, if Mr. Lulka had even talked about raising an eyebrow as a result of the insurance, it might have been something different, but his testimony was unequivocal, forthright and very clear.

MR. COPELAND: Your Honor --

THE COURT: And therefore as a result there's nothing in the record that indicates that there was a nexus between the insurance.

MR. COPELAND: Your Honor, what would have happened if I had asked Mr. Lulka, what was your opinion whether or not he was turned away for no insurance. He couldn't even testify to that legitimately. He's not an expert witness to know if --

THE COURT: You can ask -- he was asked by Mr. Paul, what did they say about the insurance, what did they do about the insurance? Was there any indication in their demeanor or words that caused one to believe that the insurance was an issue? He asked all of those questions. And your witness truthfully said no.

MR. COPELAND: The Court is placing Mr. Lulka and putting him in the place of the minds of Hillcrest Medical Center employees. That would not even stand up, I didn't think, under a court of law, Your Honor, for him to testify to that. I don't even think it's relevant for him to testify to that. What is relevant is that whenever they come in, Your

Honor, and they ask do you have insurance, and this person does not have insurance that they strongly encourage individuals to go somewhere else if they are in a triage Category III. So the mere fact, Your Honor, that if they -- there's a question of fact here. If intentionally Hillcrest Medical Center --

THE COURT: There's only a question of fact if you have got a fact to controvert Mr. Lulka's testimony.

MR. COPELAND: The fact, Your Honor, is they have a philosophy to strongly encourage. That's a question of fact.

THE COURT: Okay. All right.

MR. COPELAND: They did not re-test his vitals, Your Honor.

THE COURT: I understand that. And in the conversation that occurred in Mr. Paul's examination of Dr. Zola, they talked about whether or not the testing of Dr. Cobb would be re-testing his vitals. He found perhaps that that was an inadequate re-testing of his vitals, his view, and that's certainly for the jury to determine. But as to whether or not he got an opportunity, an undertaking to examine those issues, that undertaking was made and he so conceded.

MR. COPELAND: And, Your Honor, he's making a legal conclusion as a doctor on that question by Mr. Paul. It's the jury --

THE COURT: No, the legal conclusion was when you were asking about EMTALA.

MR. COPELAND: No, we're asking about his background in EMTALA and his experience in dealing with EMTALA, has he had patients come in in his past, prior to EMTALA, where they were dumped? Yes, he had. And as a result of that is there sometimes a phone call that is made from that other hospital where that was done? Yes, he did. Dr. Murta testified that he probably did call Hillcrest Medical Center.

THE COURT: All right. But there's a big difference between any phone call and a notification; right? You would agree?

MR. COPELAND: Your Honor, there is.

THE COURT: All right. Mr. Copeland, the Rule 50 motion as to the EMTALA claim is hereby granted under the authority of Repp vs. Anadarko and Tank vs. Chronister with particular reference to the cross—examination of your own expert, Dr. Zola, as he addressed each and every policy that was alleged to have been violated and whether or not those were -- they were in fact undertakings to comply with those policies. All right. The record reflects your objection to that ruling on Rule 50.

Mr. Paul, you are recognized for further motions, sir.

MR. PAUL: Yes, sir.

MR. COPELAND: Your Honor, may I make a quick record, please.

THE COURT: You just did. I just said you objected to

it.

MR. COPELAND Okay. Your Honor.

THE COURT I mean, you certainly can amplify it many pages over in Denver, but you've certainly got a record here.

MR. COPELAND Thank you, Your Honor.

THE COURT All right. Go ahead, Mr. Paul.

MR. COPELAND Your Honor, there were other policies but that's all right.

THE COURT All right. Go ahead.

MR. PAUL If it please the Court the next subject of the Rule 50 motion has to do with the claim of negligence. As I understood it, Dr. Zola testified there were three areas. Number one, we negligently triaged. Number two, that the cardiac protocol should have been followed, and then number three that the vitals – we violated the policy on the vitals not being retaken.

Dr. Zola never testified that the failure to do any of those things or not doing them properly or negligently was the proximate cause of his death or had any causal relationship at all to his death. And Dr. Zola further did not testify that there was any relationship between the failure, those failures and the failure of Dr. Cobb and/or the hospital to not diagnose septiceitiia. As I understood Dr. Zola's testimony it was not negligence, there was no negligence in failure to diagnose bacterial endocarditis, only that they didn't recognize some

UNITED STATES COURT OF APPEALS

FOR THE TENTH CIRCUIT

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Plaintiffs - Appellants,

v.

No. 00-5013
(D.C. No. 98-CV-829-H)

(Northern District of Oklahoma)
HILLCREST MEDICAL CENTER, an Oklahoma corporation doing business in the State of Oklahoma,

Defendant - Appellee,

and

CAROLYN COBB, a physician; EMERGENCY PHYSICIANS, INC., an Oklahoma corporation doing business in the State of Oklahoma,

Defendants.

ORDER

Filed May 9, 2001

Before **SEYMOUR**, Circuit Judge, **McWILLIAMS,,** Senior Circuit Judge, and **BELOT**, District

Appellant's motion to file a corrected petition for panel rehearing is granted.

Entered for the Court, Patrick Fisher,
Clerk of Court

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ORDER

Filed May 9, 2001

Before **SEYMOUR,** Circuit Judge, **McWILLIAMS,,** Senior

Circuit Judge, and **BELOT,** District

Appellant's petition for rehearing is denied.

Entered for the Court, Patrick Fisher,
Clerk of Court

Emergency Medical Treatment and Active Labor Act
42 U.S.C. § 1395dd

§ 1395dd **Examination and treatment for emergency medical conditions and women in labor**

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning

of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless—

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnoses, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000.00 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a-7a of this title (other that subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner

as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320-7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph **(B)**. However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in

which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of subchapter XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.

(e) Definitions

In this section:

(1) The term "emergency medical condition" means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in --

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant women who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or, occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described n paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an emergency medical condition describe in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1395x(mm)(1) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with and emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

42 U. S. C. § 1395x(r)(1)

§ 1395x Definitions

(r) Physician

The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1301(a)(7) of this title),

42 U.S.C. § 1320-7a

§ 1320a-7a. Civil monetary penalties

(a) Improperly filed claims

Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5) of this section) that--

(1) knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1) of this section), a claim (as defined in subsection (i)(2) of this section) that the Secretary determines-

(A) is for a medical or other item or service that the person knows or should know was not provided as claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,

(B) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent,

(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service--

(i) was not licensed as a physician,

(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including

cheating on an examination required for licensing), or

(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified,

(D) is for a medical or other item or service furnished during a period in which the person was excluded from the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1320a-7, 1320c-5, 1320c-9(b) (as in effect on September 2, 1982), 1395y(d) (as in effect on August 18, 1987), or 1395cc(b) of this title or as a result of the application of the provisions of section 1395u(j)(2) of this title, or

(E) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;

(2) knowingly presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1395u(b)(3)(B)(ii) of this title, or (B) an agreement with a State agency (or other requirement of a State plan under subchapter XIX of this chapter) not to charge a person for an item or service in excess of the amount permitted to be charged, or (C) an agreement to be a participating physician or supplier under section 1395u(h)(1) of this title, or (D) an agreement pursuant to section 1395cc(a)(1)(G) of this title;

(3) knowingly gives or causes to be given to any person, with respect to coverage under subchapter XVIII of this chapter of inpatient hospital services subject to the provisions of section 1395ww of this title, information that he knows or should know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person or another individual from the hospital;

(4) in the case of a person who is not an organization, agency,

or other entity, is excluded from participating in a program under subchapter XVIII of this chapter or a State health care program in accordance with this subsection or under section 1320a-7 of this title and who, at the time of a violation of this subsection--

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under subchapter XVIII of this chapter or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(B) is an officer or managing employee (as defined in section 1320a-5(b) of this title) of such an entity;

(5) offers to or transfers remuneration to any individual eligible for benefits under subchapter XVIII of this chapter, or under a State health care program (as defined in section 1320a-7(h) of this title) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under subchapter XVIII of this chapter, or a State health care program (as so defined);

(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1320a-7b(f) of this title), for the provision of items or services for which payment may be made under such a program; or

(7) commits an act described in paragraph (1) or (2) of section 1320a-7b(b) of this title;

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each item or service (or, in cases under paragraph

(3), $15,000 for each individual with respect to whom false or misleading information was given; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs; or in cases under paragraph (7), $50,000 for each such act). In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim (or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose). In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1320a-7b(f)(1) of this title) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

(b) Payments to induce reduction or limitation of services

(1) If a hospital or a critical access hospital knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who--

(A) are entitled to benefits under part A or part B of subchapter XVIII of this chapter or to medical assistance under a State plan approved under subchapter XIX of this chapter, and

(B) are under the direct care of the physician,

the hospital or a critical access hospital shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each such individual with respect to whom the payment is made.

(2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each individual described in such paragraph with respect to whom the payment is made.

(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of--

(i) $5,000, or

(ii) three times the amount of the payments under subchapter XVIII of this chapter for home health services which are made pursuant to such certification.

(B) A document described in this subparagraph is any document that certifies, for purposes of subchapter XVIII of this chapter, that an individual meets the requirements of section 1395f(a)(2)(C) or 1395n(a)(2)(A) of this title in the case of home health services furnished to the individual.

(c) Initiation of proceeding; authorization by Attorney General, notice, etc.; estoppel, failure to comply with order or procedure

(1) The Secretary may initiate a proceeding to determine whether to impose a civil money penalty, assessment, or exclusion under subsection (a) or (b) of this section only as authorized by the Attorney General pursuant to procedures agreed upon by them. The Secretary may not initiate an action under this section with respect to any claim, request for payment, or other occurrence described in this section later than six years after the date the claim was presented, the request for payment was made, or the occurrence took place. The Secretary

may initiate an action under this section by serving notice of the action in any manner authorized by Rule 4 of the Federal Rules of Civil Procedure.

(2) The Secretary shall not make a determination adverse to any person under subsection (a) or (b) of this section until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

(3) In a proceeding under subsection (a) or (b) of this section which--

(A) is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and

(B) involves the same transaction as in the criminal action,

the person is estopped from denying the essential elements of the criminal offense.

(4) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include--

(A) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established,

(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense,

(C) striking pleadings, in whole or in part,

(D) staying the proceedings,

(E) dismissal of the action,

(F) entering a default judgment,

(G) ordering the party or attorney to pay attorneys' fees and other costs caused by the failure or misconduct, and

(H) refusing to consider any motion or other action which is not filed in a timely manner.

(d) Amount or scope of penalty, assessment, or exclusion

In determining the amount or scope of any penalty, assessment, or exclusion imposed pursuant to subsection (a) or (b) of this section, the Secretary shall take into account--

(1) the nature of claims and the circumstances under which they were presented,

(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and

(3) such other matters as justice may require.

(e) Review by courts of appeals

Any person adversely affected by a determination of the Secretary under this section may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the claim was

presented, by filing in such court (within sixty days following the date the person is notified of the Secretary's determination) a written petition requesting that the determination be modified or set aside. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, and thereupon the Secretary shall file in the Court [FN1] the record in the proceeding as provided in section 2112 of Title 28. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the determination of the Secretary and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been urged before the Secretary shall be considered by the court, unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances. The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive. If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and to be made a part of the record. The Secretary may modify his findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and he shall file with the court such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order. Upon the filing of the record with it, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of Title 28.

(f) Compromise of penalties and assessments; recovery; use of funds recovered

Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1)(A) In the case of amounts recovered arising out of a claim under subchapter XIX of this chapter, there shall be paid to the State agency an amount bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid for such claim.

(B) In the case of amounts recovered arising out of a claim under an allotment to a State under subchapter V of this chapter, there shall be paid to the State agency an amount equal to three-sevenths of the amount recovered.

(2) Such portion of the amounts recovered as is determined to have been paid out of the trust funds under sections 1395i and 1395t of this title shall be repaid to such trust funds.

(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1320a-7b(f) of this title), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Insurance Portability and Accountability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1395i(k)(2)(C) of this title.

(4) The remainder of the amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States.

The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty or assessment has been assessed.

(g) Finality of determination respecting penalty, assessment, or exclusion

A determination by the Secretary to impose a penalty, assessment, or exclusion under subsection (a) or (b) of this section shall be final upon the expiration of the sixty-day period referred to in subsection (e) of this section. Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection (e) of this section may not be raised as a defense to a civil action by the United States to collect a penalty, assessment, or exclusion assessed under this section.

(h) Notification of appropriate entities of finality of determination

Whenever the Secretary's determination to impose a penalty, assessment, or exclusion under subsection (a) or (b) of this section becomes final, he shall notify the appropriate State or local medical or professional organization, the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1320a-7(h) of this title), and the appropriate utilization and quality control peer review organization, and the appropriate State or local licensing agency or organization

(including the agency specified in section 1395aa(a) and 1396a(a)(33) of this title) that such a penalty, assessment, or exclusion has become final and the reasons therefor.

(i) Definitions

For the purposes of this section:

(1) The term "State agency" means the agency established or designated to administer or supervise the administration of the State plan under subchapter XIX of this chapter or designated to administer the State's program under subchapter V of this chapter or subchapter XX of this chapter.

(2) The term "claim" means an application for payments for items and services under a Federal health care program (as defined in section 1320a-7b(f) of this title).

(3) The term "item or service" includes (A) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, and (B) in the case of a claim based on costs, any entry in the cost report, books of account or other documents supporting such claim.

(4) The term "agency of the United States" includes any contractor acting as a fiscal intermediary, carrier, or fiscal agent or any other claims processing agent for a Federal health care program (as so defined).

(5) The term "beneficiary" means an individual who is eligible to receive items or services for which payment may be made under a Federal health care program (as so defined) but does not include a provider, supplier, or practitioner.

(6) The term "remuneration" includes the waiver of coinsurance and deductible amounts (or any part thereof), and

transfers of items or services for free or for other than fair market value. The term "remuneration" does not include--

(A) the waiver of coinsurance and deductible amounts by a person, if--

(i) the waiver is not offered as part of any advertisement or solicitation;

(ii) the person does not routinely waive coinsurance or deductible amounts; and

(iii) the person--

(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or

(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts;

(III) Repealed. Pub.L. 105-33, Title IV, § 4331(e)(1)(C), Aug. 5, 1997, 111 Stat. 396

(B) subject to subsection (n), any permissible practice described in any subparagraph of section 1320a-7b(b)(3) of this title or in regulations issued by the Secretary;

(C) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after August 21, 1996; or

(D) [FN2] incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated.

(D) [FN2] a reduction in the copayment amount for covered OPD services under section 1395l(t)(5)(B) of this title.

(7) The term "should know" means that a person, with respect to information--

(A) acts in deliberate ignorance of the truth or falsity of the information; or

(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.

(j) Subpoenas

(1) The provisions of subsections (d) and (e) of section 405 of this title shall apply with respect to this section to the same extent as they are applicable with respect to subchapter II of this chapter. The Secretary may delegate the authority granted by section 405(d) of this title (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.

(2) The Secretary may delegate authority granted under this section and under section 1320a-7 of this title to the Inspector General of the Department of Health and Human Services.

(k) Injunctions

Whenever the Secretary has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty

under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.

(l) Liability of principal for acts of agent

A principal is liable for penalties, assessments, and an exclusion under this section for the actions of the principal's agent acting within the scope of the agency.

(m) Claims within jurisdiction of other departments or agencies

(1) For purposes of this section, with respect to a Federal health care program not contained in this chapter, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 (5 U.S.C. App.) with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.

(n)(1) Subparagraph (B) of subsection (i)(6) shall not apply to a practice described in paragraph (2) unless--

(A) the Secretary, through the Inspector General of the Department of Health and Human Services, promulgates a rule authorizing such a practice as an exception to remuneration; and

(B) the remuneration is offered or transferred by a person under such rule during the 2-year period beginning on the date the rule is first promulgated.

(2) A practice described in this paragraph is a practice under which a health care provider or facility pays, in whole or in part, premiums for medicare supplemental policies for individuals entitled to benefits under part A of subchapter XVIII of this chapter [42 U.S.C.A. § 1395c et seq.] pursuant to section 426-1 of this title.

[FN1] So in original. Probably should be "court".

[FN2] So in original. Two subparagraphs (D) have been enacted.

U. S. CONT. Art. I, II, and III

The Constitution of United States

We the People of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defense, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America.

Article I

Section 1. All legislative Powers herein granted shall be vested in a Congress of the United States, which shall consist of a Senate and House of Representatives.

Section 2. [1] The House of Representatives shall be composed of Members chosen every second Year by the People of the several States, and the Electors in each State shall have the Qualifications requisite for Electors of the most numerous Branch of the State Legislature.

[2] No Person shall be a Representative who shall not have attained to the age of twenty five Years, and been seven Years a Citizen of the United States, and who shall not, when elected, be an Inhabitant of that State in which he shall be chosen.

[3] Representatives and direct Taxes shall be apportioned among the several States which may be included within this Union, according to their respective Numbers, which shall be determined by adding to the whole Number of free Persons, including those bound to Service for a Term of Years, and excluding Indians not taxed, three fifths of all other Persons. The actual Enumeration shall be made within three Years after the first Meeting of the Congress of the United States, and within every subsequent Term of ten Years, in such Manner as they shall by Law direct. The Number of Representatives shall not exceed one for every thirty Thousand, but each State shall have at Least one Representative; and until such enumeration shall be made, the State of New Hampshire

shall be entitled to chuse three, Massachusetts eight, Rhode-Island and Providence Plantations one, Connecticut five, New-York six, New Jersey four, Pennsylvania eight, Delaware one, Maryland six, Virginia ten, North Carolina five, South Carolina five, and Georgia three.

[4] When vacancies happen in the Representation from any State, the Executive Authority thereof shall issue Writs of Election to fill such Vacancies.

[5] The House of Representatives shall chuse their Speaker and other Officers; and shall have the sole Power of Impeachment.

Section 3. [1] The Senate of the United States shall be composed of two Senators from each State, chosen by the Legislature thereof, for six Years; and each Senator shall have one Vote.

[2] Immediately after they shall be assembled in Consequence of the first Election, they shall be divided as equally as may be into three Classes. The Seats of the Senators of the first Class shall be vacated at the Expiration of the second Year, of the second Class at the Expiration of the fourth Year, and of the third Class at the Expiration of the sixth Year, so that one third may be chosen every second Year; and if Vacancies happen by Resignation, or otherwise, during the Recess of the Legislature of any State, the Executive thereof may make temporary Appointments until the next Meeting of the Legislature, which shall then fill such Vacancies.

[3] No Person shall be a Senator who shall not have attained to the Age of thirty Years, and been nine Years a Citizen of the United States, and who shall not, when elected, be an Inhabitant of that State for which he shall be chosen.

[4] The Vice President of the United States shall be President of the Senate but shall have no Vote, unless they be equally divided.

[5] The Senate shall chuse their other Officers, and also a President pro tempore, in the Absence of the Vice President, or when he shall exercise the Office of President of the United States.

[6] The Senate shall have the sole Power to try all Impeachments. When sitting for that Purpose, they shall be on

Oath or Affirmation. When the President of the United States is tried the Chief Justice shall preside: And no Person shall be convicted without the Concurrence of two thirds of the Members present.

[7] Judgment in Cases of Impeachment shall not extend further than to removal from Office, and disqualification to hold and enjoy any Office of honor, Trust or Profit under the United States: but the Party convicted shall nevertheless be liable and subject to Indictment, Trial, Judgment and Punishment, according to Law.

Section 4. [1] The Times, Places and Manner of holding Elections for Senators and Representatives, shall be prescribed in each State by the Legislature thereof; but the Congress may at any time by Law make or alter such Regulations, except as to the Places of chusing Senators.

[2] The Congress shall assemble at least once in every Year, and such Meeting shall be on the first Monday in December, unless they shall by Law appoint a different Day.

Section 5. [1] Each House shall be the Judge of the Elections, Returns and Qualifications of its own Members, and a Majority of each shall constitute a Quorum to do Business; but a smaller Number may adjourn from day to day, and may be authorized to compel the Attendance of absent Members, in such Manner, and under such Penalties as each House may provide.

[2] Each House may determine the Rules of its Proceedings, punish its Members for disorderly Behavior, and, with the Concurrence of two thirds, expel a Member.

[3] Each House shall keep a Journal of its Proceedings, and from time to time publish the same, excepting such Parts as may in their Judgment require Secrecy; and the Yeas and Nays of the Members of either House on any question shall, at the Desire of one fifth of those Present, be entered on the Journal.

[4] Neither House, during the Session of Congress, shall, without the Consent of the other, adjourn for more than three days, nor to any other Place than that in which the two Houses shall be sitting.

Section 6. [1] The Senators and Representatives shall receive a Compensation for their Services, to be ascertained by

Law, and paid out of the Treasury of the United States. They shall in all Cases, except Treason, Felony and Breach of the Peace, be privileged from Arrest during their Attendance at the Session of their respective Houses, and in going to and returning from the same; and for any Speech or Debate in either House, they shall not be questioned in any other Place.

[2] No Senator or Representative shall, during the Time for which he was elected, be appointed to any civil Office under the Authority of the United States, which shall have been created, or the Emoluments whereof shall have been encreased during such time; and no Person holding any Office under the United States, shall be a Member of either House during his Continuance in Office.

Section 7. [1] All Bills for raising Revenue shall originate in the House of Representatives; but the Senate may propose or concur with amendments as on other Bills.

[2] Every Bill which shall have passed the House of Representatives and the Senate, shall, before it become a law, be presented to the President of the United States: If he approve he shall sign it, but if not he shall return it, with his Objections to that House in which it shall have originated, who shall enter the Objections at large on their Journal, and proceed to reconsider it. If after such Reconsideration two thirds of that House shall agree to pass the Bill, it shall be sent, together with the Objections, to the other House, by which it shall likewise be reconsidered, and if approved by two thirds of that House, it shall become a Law. But in all such Cases the Votes of both Houses shall be determined by Yeas and Nays, and the Names of the Persons voting for and against the Bill shall be entered on the Journal of each House respectively. If any Bill shall not be returned by the President within ten Days (Sundays excepted) after it shall have been presented to him, the Same shall be a Law, in like Manner as if he had signed it, unless the Congress by their Adjournment prevent its Return, in which Case it shall not be a Law

[3] Every Order, Resolution, or Vote to which the Concurrence of the Senate and House of Representatives may be necessary (except on a question of Adjournment) shall be presented to the President of the United States; and before the

Same shall take Effect, shall be approved by him, or being disapproved by him, shall be repassed by two thirds of the Senate and House of Representatives, according to the Rules and Limitations prescribed in the Case of a Bill.

Section 8. [1] The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States;

[2] To borrow Money on the credit of the United States;

[3] To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes;

[4] To establish an uniform Rule of Naturalization, and uniform Laws on the subject of Bankruptcies throughout the United States;

[5] To coin Money, regulate the Value thereof, and of foreign Coin, and fix the Standard of Weights and Measures;

[6] To provide for the Punishment of counterfeiting the Securities and current Coin of the United States;

[7] To establish Post Offices and post Roads;

[8] To promote the Progress of Science and useful Arts, by securing for limited Times to Authors and Inventors the exclusive Right to their respective Writings and Discoveries;

[9] To constitute Tribunals inferior to the supreme Court;

[10] To define and punish Piracies and Felonies committed on the high Seas, and Offences against the Law of Nations;

[11] To declare War, grant Letters of Marque and Reprisal, and make Rules concerning Captures on Land and Water;

[12] To raise and support Armies, but no Appropriation of Money to that Use shall be for a longer Term than two Years;

[13] To provide and maintain a Navy;

[14] To make Rules for the Government and Regulation of the land and naval Forces;

[15] To provide for calling forth the Militia to execute the Laws of the Union, suppress Insurrections and repeal Invasions;

[16] To provide for organizing, arming, and disciplining, the Militia, and for governing such Part of them as may be employed in the Service of the United States, reserving to the States respectively, the Appointment of the Officers, and the Authority of training the Militia according to the discipline prescribed by Congress;

[17] To exercise exclusive Legislation in all Cases whatsoever, over such District (not exceeding ten Miles square) as may, by Cession of Particular States, and the Acceptance of Congress, become the Seat of the Government of the United States, and to exercise like Authority over all Places purchased by the Consent of the Legislature of the State in which the Same shall be, for the Erection of Forts, Magazines, Arsenals, dock-Yards and other needful Buildings;--And

[18] To make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof.

Section 9. [1] The Migration or Importation of such Persons as any of the States now existing shall think proper to admit, shall not be prohibited by the Congress prior to the Year one thousand eight hundred and eight, but a Tax or duty may be imposed on such Importation, not exceeding ten dollars for each Person.

[2] The Privilege of the Writ of Habeas Corpus shall not be suspended, unless when in Cases or Rebellion or Invasion the public Safety may require it.

[3] No Bill of Attainder or ex post facto Law shall be passed.

[4] No Capitation, or other direct, Tax shall be laid, unless in Proportion to the Census of Enumeration herein before directed to be taken.

[5] No Tax or Duty shall be laid on Articles exported from any State.

[6]No Preference shall be given by any Regulation of Commerce or Revenue to the Ports of one State over those of another: nor shall Vessels bound to, or from, one State, be obliged to enter, clear or pay Duties in another.

[7] No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law; and a regular Statement and Account of the Receipts and Expenditures of all public Money shall be published from time to time.

[8] No Title of Nobility shall be granted by the United States: And no Person holding any Office of Profit or Trust under them, shall, without the Consent of the Congress, accept of any present, Emolument, Office, or Title, of any kind whatever, from any King, Prince or foreign State.

Section 10. [1] No State shall enter into any Treaty, Alliance, or Confederation; grant Letters of Marque and Reprisal; coin Money; emit Bills of Credit; make any Thing but gold and silver Coin a Tender in Payment of Debts; pass any Bill of Attainder, ex post facto Law, or Law impairing the Obligation of Contracts, or grant any Title of Nobility.

[2] No State shall, without the Consent of the Congress, lay any Imposts or Duties on Imports or Exports, except what may be absolutely necessary for executing it's inspection Laws: and the net Produce of all Duties and Imposts, laid by any State on Imports or Exports, shall be for the Use of the Treasury of the United States; and all such Laws shall be subject to the Revision and Controul of the Congress.

[3] No State shall, without the Consent of Congress, lay any Duty of Tonnage, keep Troops, or Ships of War in time of Peace, enter into any Agreement or Compact with another State, or with a foreign Power, or engage in War, unless actually invaded, or in such imminent Danger as will not admit of delay.

Article II.

Section 1. [1] The executive Power shall be vested in a President of the United States of America. He shall hold his Office during the Term of four Years, and, together with the Vice President, chosen for the same Term, be elected, as follows:

[2] Each State shall appoint, in such Manner as the Legislature thereof may direct, a Number of Electors, equal to the whole Number of Senators and Representatives to which the State may be entitled in the Congress: but no Senator or

Representative, or Person holding an Office of Trust or Profit under the United States, shall be appointed an Elector.

[3] The Electors shall meet in their respective States, and vote by Ballot for two Persons, of whom one at least shall not be an Inhabitant of the same State with themselves. And they shall make a List of all the Persons voted for, and of the Number of Votes for each; which List they shall sign and certify, and transmit sealed to the Seat of the Government of the United States, directed to the President of the Senate. The President of the Senate shall, in the Presence of the Senate and House of Representatives, open all the Certificates, and the Votes shall then be counted. The Person having the greatest Number of Votes shall be the President, if such Number be a Majority of the whole Number of Electors appointed; and if there be more than one who have such Majority, and have an equal Number of Votes, then the House of Representatives shall immediately chuse by Ballot one of them for President; and if no Person have a Majority, then from the five highest on the List the said House shall in like Manner chuse the President. But in chusing the President, the Votes shall be taken by States, the Representatives from each State having one Vote; a quorum for this Purpose shall consist of a Member or Members from two thirds of the States, and a Majority of all the States shall be necessary to a Choice. In every Case, after the Choice of the President, the Person having the greatest Number of Votes of the Electors shall be the Vice President. But if there should remain two or more who have equal Votes, the Senate shall chuse from them by Ballot the Vice President.

[4] The Congress may determine the Time of chusing the Electors, and the Day on which they shall give their Votes; which Day shall be the same throughout the United States.

[5] No Person except a natural born Citizen, or a Citizen of the United States, at the time of the Adoption of this Constitution, shall be eligible to the Office of President; neither shall any person be eligible to that Office who shall not have attained to the Age of thirty five Years, and been fourteen Years a Resident within the United States.

[6] In Case of the Removal of the President from Office, or of his Death, Resignation, or Inability to discharge the

Powers and Duties of the said Office, the Same shall devolve on the Vice President, and the Congress may by Law provide for the Case of Removal, Death, Resignation or Inability, both of the President and Vice President, declaring what Officer shall then act as President, and such Officer shall act accordingly, until the Disability be removed, or a President shall be elected.

[7] The President shall, at stated Times, receive for his Services, a Compensation, which shall neither be encreased nor diminished during the Period for which he shall have been elected, and he shall not receive within that Period any other Emolument from the United States, or any of them.

Before he enter on the Execution of his Office, he shall take the following Oath or Affirmation:--"I do solemnly swear (or affirm) that I will faithfully execute the Office of President of the United States, and will to the best of my Ability, preserve, protect and defend the Constitution of the United States."

Section 2. [1] The President shall be Commander in Chief of the Army and Navy of the United States, and of the Militia of the several States, when called into the actual Service of the United States; he may require the Opinion, in writing, of the principal Officer in each of the executive Departments, upon any Subject relating to the Duties of their respective Offices, and he shall have Power to Grant Reprieves and Pardons for Offences against the United States, except in Cases of Impeachment.

[2] He shall have Power, by and with the Advice and Consent of the Senate, to make Treaties, provided two thirds of the Senators present concur; and he shall nominate, and by and with the Advice and Consent of the Senate, shall appoint Ambassadors, other public Ministers and Consuls, Judges of the supreme Court, and all other Officers of the United States, whose Appointments are not herein otherwise provided for, and which shall be established by Law: but the Congress may by Law vest the Appointment of such inferior Officers, as they think proper, in the President alone, in the Courts of Law, or in the Heads of Departments.

[3] The President shall have Power to fill up all Vacancies that may happen during the Recess of the Senate, by

granting Commissions which shall expire at the End of their next Session.

Section 3. He shall from time to time give to the Congress Information on the State of the Union, and recommend to their Consideration such Measures as he shall judge necessary and expedient; he may, on extraordinary Occasions, convene both Houses, or either of them, and in Case of Disagreement between them, with Respect to the Time of Adjournment, he may adjourn them to such Time as he shall think proper; he shall receive Ambassadors and other public Ministers; he shall take Care that the Laws be faithfully executed, and shall Commission all the Officers of the United States.

Section 4. The President, Vice President and all Civil Officers of the United States, shall be removed from Office on Impeachment for and Conviction of, Treason, Bribery, or other high Crimes and Misdemeanors.

Article III.

Section 1.

The judicial Power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish. The Judges, both of the supreme and inferior Courts, shall hold their Offices during good Behaviour, and shall, at stated Times, receive for their Services, a Compensation, which shall not be diminished during their Continuance in Office.

Section 2. [1] The judicial Power shall extend to all Cases, in Law and Equity, arising under this Constitution, the Laws of the United States, and Treaties made, or which shall be made, under their Authority;--to all Cases affecting Ambassadors, other public ministers and Consuls;--to all Cases of admiralty and maritime Jurisdiction;--to Controversies to which the United States shall be a Party;--to Controversies between two or more States;--between a State and Citizens of another State;--between Citizens of different States;--between Citizens of the same State claiming Lands under Grants of

different States, and between a State, or the Citizens thereof, and foreign States, Citizens or Subjects.

[2] In all Cases affecting Ambassadors, other public Ministers and Consuls, and those in which a State shall be Party, the supreme Court shall have original Jurisdiction. In all the other Cases before mentioned, the supreme Court shall have appellate Jurisdiction, both as to Law and Fact, with such Exceptions, and under such Regulations as the Congress shall make.

[3] The Trial of all Crimes, except in Cases of Impeachment, shall be by Jury; and such Trial shall be held in the State where the said Crimes shall have been committed; but when not committed within any State, the Trial shall be at such Place or Places as the Congress may by Law have directed.

Section 3. [1] Treason against the United States, shall consist only in levying War against them, or in adhering to their Enemies, giving them Aid and Comfort. No Person shall be convicted of Treason unless on the Testimony of two Witnesses to the same overt Act, or on Confession in open Court.

[2] The Congress shall have Power to declare the Punishment of Treason, but no Attainder of Treason shall work Corruption of Blood, or Forfeiture except during the Life of the Person attainted.

Case No. 00-5013

IN AND FOR THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

CRYSTAL STAR PHILLIPS, individually, and As next of kin to Martin Shane, on behalf of THE ESTATE OF MARTIN SHANE PHILLIPS By and through her mother, legal guardian and Next friend, MINNIE CHRISTINA DACZEWITZ, and FRED MARTIN PHILLIPS JR., parent of Martin Shane Phillips	)
the Appellants,	)
vs.	)
HILLCREST MEDICAL CENTER, an Oklahoma corporation doing business in the State of Oklahoma,	)
the Appellee.	)

On Appeal from the United States District Court
For the Northern District of Oklahoma

The Honorable Sven Erik Holmes
District Judge

U. S. District Court Case No. 98-CV-829

APPELLANTS' OPENING BRIEF
(substituted)

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STATEMENT OF RELATED APPEALS:

This case has no history except the first trial, which is no being appealed.

APPELLANTS' OPENING BRIEF

THESE APPELLANTS, Crystal Star Phillips, the Estate of Martin Shane Phillips, and Fred Phillips, Jr., ("Plaintiffs") hereby submit their Opening Brief pursuant to Fed. R. App. P. Rule 28, and Rule 28.2 for the Tenth Circuit.

I. STATEMENT OF SUBJECT MATTER AND APPELLATE JURISDICTION

Congress has vested this Court of Appeals with jurisdiction to hear appeals from all final orders of the Northern District of Oklahoma. *28 U .S .C. A. §1291.* This Court has subject matter jurisdiction because this appeal arises from a final order in a civil case brought in the Northern District of Oklahoma for violation of the Emergency Medical Treatment and Active Labor Act, ("EMTALA"), specifically *42 U.S.C.A. § 1395dd(a).* In addition, Plaintiffs, were granted supplemental jurisdiction for state pendent actions of negligence against Hillcrest Medical Center, ("Defendant"). Plaintiffs properly filed their Notice for Appeal on January 21, 2000, which is less than thirty (30) days from the entry of the final order of judgment rendered against Plaintiffs filed on the "civil docket" on December 23, 1999. Therefore, this Court has Appellate Jurisdiction pursuant to *28 U .S. C. A. §1291* and *Fed. R. P. Rule 4,* as a right.

II. STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

1. The trial court committed reversible error when it sustained Defendant's Rule 50 motion thereby precluding Plaintiffs' EMTALA claim from being submitted to the jury.

2. The trial court committed reversible error when it admitted allegations of potential drug use of the decedent, Martin Shane Phillips.

3. The trial court committed reversible error when it excluded Plaintiffs' substantial right to rebut with expert testimony and medical records, Defendants' affirmative defense for contributory negligence that Phillips caused his own death by failing to disclose "alleged" prior drug use.

4. The trial committed reversible error when it did not allow Plaintiffs to cross-examine the hospital's triage nurse as to why there were eleven (11) patients with chest pain in the emergency room side of the department and only the decedent Martin Shane Phillips and one other person with chest pain on the minor care side of the emergency room.

III. STATEMENT OF THE CASE

On September 28, 1998, Martin Shane Phillips, ("Phillips"), age twenty-five (25), died in the emergency room of Tulsa Regional Medical Center, ("TRMC"). TRMC is a hospital affiliated with the Defendant hospital, Hillcrest Medical Center, ("HMC"). *Vol. II, p. 880, ln 6-11.* The decedent died at the sister hospital only 4.5 days after he received only cursory and token treatment in the emergency room of HMC. *Vol. II, p. 504, ln 4-21, Vol. IV, medical chart TRMC, Plaintiffs' #40; also, Vol. IV, Agreed Amended Pretrial Order, p. 3, #23.* Plaintiffs brought suit in the Northern District of Oklahoma for actions sounding in tort for wrongful death because of violation of the federal law of EMTALA for intentionally deciding not to determine if Phillips had an emergency medical condition, failing to treat the decedent in the emergency room commensurate with HMC's own policies and procedures, and for treating Phillips differently than other patients in similar medical circumstances for the reason HMC believed the decedent did not have insurance. *Appendix Vol. IV, Agreed Amended Pretrial Order, p. 3, #3, #14, #16,* #18, #19. Also, Plaintiffs brought state pendent actions of negligence. *Id. at p. 2, #4 thru #9.* The trial court granted HMC's Rule 50 motion at

the close of Plaintiffs' evidence. *See Ruling Attachment A.* The negligence actions continued through the close of trial and a jury verdict in favor of all Defendants was entered.

IV. STATEMENT OF NARRATIVE FACTS

On Wednesday, September 23, 1998, Martin Shane Phillips, ("Phillips") at approximately 1:05 p.m., presented to the HMC emergency room with "tremendous pain" in his chest, an "ashen", "pale", "greenish" color, sweating (i.e., diaphoresis), tachycardia (i.e., rapid heart beat), a blood pressure of 129/55, "weakness", the "sound of fluid" on his lungs, "like walking pneumonia", "seizures", "felt miserable", "color was real bad", he was "shaking", he had the "chills", and he would "clench" in pain upon any movement, and he had "no insurance card". *Vol. II, p. 738, ln 22-25; the following cites are in Vol. I, p. 199, 4; p. 203 ln 1-11 ; p. 205 ln 18-20 ; p. 206 ln 1-25 ; p. 61 ln 5 ; p. 61 ln 10-19 ; p. 76 ln 1-14; p. 76 ln 18-25; p. 77, 2-11 ; p. 224, ln 20-42; p. 225 ln 2-7 ; p. 81 ln 11-25 – p. 82 ln 7; p. 88 ln 11-20.* The medical chart generated by HMC, indicates that Phillips was seen at 1:25 p.m. by a registered nurse, Lugenia Cue ("Cue"). However, Phillips presented to the emergency room via transport by his friend, Michael Lulka, ("Lulka"), who testified at trial that no one saw Phillips before registration took place approximately 30 minutes after their arrival to the emergency room. *Vol. I, p. 201, 2-11.* The chart also indicates that Phillips was registered by HMC registration personnel at 1:30 p.m. as a patient with "no insurance card". *Vol. IV, medical chart, Plaintiffs' #89.*

Phillips, while waiting to be seen, had tears in his eyes, and was almost lying down, "slumped over" in the waiting area of HMC. *Vol I, p. 203 ln 1-11.* After registration, Phillips waited approximately two more hours, before being taken to the area where patients are evaluated and was allegedly seen by Dr. Carolyn Cobb, ("Dr. Cobb"). *Id., also Vol I, p. 206, 25; Vol. IV, medical chart, Plaintiffs' #89.*

Phillips, according to the medical chart, was given a "parafon forte" and two prescriptions, one for naprosyn and one for naproxsyn, for "cervical spasms" at 4:25 p.m. and was discharged at 4:30 p.m. for referral to make an appointment with the O.U. Family Clinic, a "free clinic" for those with "no insurance and financial ability to pay. *Vol. ll pp. 993, 13-25; 994, 7-8; Vol. IV, medical chart, Plaintiffs' #89.* This occurred all while Phillips' chest pain was unevalutated, not screened, and ignored by medical personnel. *Vol. ll p. 504 ln 1-21.* It was the chest pain, which Defendants left unevaluated and unscreened, which caused Phillips' death 4.5 days later. Id., also *Vol. II p. 931 ln 7-13 ; p. 948, ln 9-11, Vol. IV, medical chart TRMC, Plaintiffs' #40.* Dr. Cobb's own expert, Dr. William Henry Bernauer, testified that at the time Phillips presented to Dr. Cobb, his heart was infected with vegetations of bacteria, which eventually caused Phillips death. *Vol. II p. 931 ln 7-13; p. 948, ln 9-11.*

Prior to his presentation on that Wednesday, Phillips was suffering in his bed for two days, and his friend Lulka was notified by the family of Phillips' landlord that someone needed to take Phillips to the doctor. *Vol. I, p. 198, 7-14; p. 70, 1-5; p. 72, 9-10; p. 76, 5-21.* Phillips was originally taken to Eastside Family Practice ("Eastside"), where Barbara Hight, ("Hight"), Eastside's intake personnel, observed Phillips and testified he did not look well, he had an "ashen" appearance, and he needed to go to the emergency room at a hospital. *Vol. p. 61, 5-19; p. 200 ln 3-11.* Hight, from Eastside, and Phillips' co-workers Lulka, and Daczewitz all testified and plainly observed Phillips' ill appearance just prior or contemporaneous with Phillips' presentation to HMC. *Vol. l, p. 76, ln 1-11; ln 18-25; p. 61, ln 10-19; p .198, ln 19-25; p. 199, ln 4; p. 203 ln 1-11; p. 205, ln 18-25; p. 206, ln 1-25; p. 225, ln 2-7;* Moreover, a trained emergency medical technician, an "EMT", Phillips' boss, who is experienced in transporting many "sick" people to the hospital, described Phillips on that Tuesday (the day before Phillips presentation to HMC), or Wednesday, (the same day Phillips visited HMC), as "very bad, very bad", "real pale, sweaty...like a zombie, like walking dead". *Vol II,*

p. 733, ln 19-25; p. 738, ln 22-24; p. 739, ln 1-3. Nothing like this is mentioned in the HMC medical chart. *Vol. lV, medical chart Plaintiffs' #89.* Much is not mentioned in the medical chart. *Id.*

For instance, Dr. Cobb, who claims to have seen Phillips on that day, states nothing in her dictation about Phillips' poor appearance. *Vol. lV see dictation, medical chart, Plaintiffs' #89.* To the contrary, Dr. Cobb states in her dictation that Phillips is a "pleasant gentleman", that "the examination is very unremarkable", and expounded on this at trial testifying that when she entered the examining room, Phillips was sitting quietly on the table and "he didn't appear to be in any distress". *Id.,* and *Vol. l p. 286 ln 2-5.* This is a far cry from the symptoms of which three lay persons and a trained emergency medical technician had just characterized Phillips at or about that same time. *Vol. ll p. 734, 1-6; p. 738, 22-25; p. 739,1-3; Vol. l, 77, 2-11; p. 81, 11-25; p. 82, 1-7; p. 205, 18-25; p. 206, 1-25.*

For the medical record on September 23, 1998, the day Phillips presented to HMC, incredibly, Dr. Cobb left the entire area blank, which pertains to the physician's report, physician's history and physical exam, and the physician's initial impression and plan. *Vol. II, p. 504, ln 4-21; IV, medical chart Plaintiffs' # 89(see page labeled at bottom of page as "Emergency Dept. Treatment Record").* In addressing these subjects, "allegedly" two days later while making her dictation on Phillips, Dr. Cobb supposedly utilizes the "face sheet" and the "review of systems" sheet by taking only these two sheets home with her to dictate her alleged encounter with Phillips. *Vol. I, P. 257 ln 8-17.* Neither of these two sheets contain the precise vital signs of blood pressure 129/55, pulse 112, respirations 16, and temperature 98, yet; these show up in her dictation. *Vol. IV, medical chart, Plaintiffs' #89.* Not only do these precise vital signs show up in her dictation, but so do many other statements not on the two pages she claims to have utilized for her dictation: "stiff neck for three weeks"; "patient ...has had chest pain since yesterday", "denies...sputum production", "no sore throat", "lungs clear to auscultation", "no

increased respiratory effort", heart: "rate is regular" "no murmur or gallop, "pupils are equal, round and reactive to light", "gaze" is conjugate". *Id.*

Plaintiffs contended that HMC had destroyed, withheld and manipulated documents to mask their EMTALA violation. *Vol, IV, Agreed Pretrial Order, p. 3 #15, p. 5 #40.* Christina Dacewitz, the mother of Phillips' only child, testified when she visited HMC in early October 1998 in attempt to obtain the medical chart on Phillips, she saw the original "face sheet" for Phillips, which stated in a woman's handwriting, "NO INSURANCE". *Vol. ll p. 780, ln 10-20; p. 781, ln 3-23; p. 807, ln 8-15, Vol. IV, Plaintiffs' #12.* This document is not in the medical chart. *Vol. lV, medical chart, Plaintiffs' #89.*

Plaintiffs have other evidence probative of document tampering. Particularly eyebrow raising, is Plaintiffs' exhibit 45, admitted into evidence. *Vol. lV, triage sheet, #45.* This piece of evidence is a triage sheet for a male patient, who appears to be triaged as a category III, like Phillips, and much of the documentation clearly looks to be whited out as if an attempt was made to change it. *Vol. lV, triage sheet, Plaintiffs' #45, also medical chart, Plaintiffs' #89.*

In addition, the "review of systems" sheet, which is what establishes Defendants' only affirmative defense, was not signed by Phillips on the line required for his signature, -- "Patient/Responsible Person's Signature". *Vol. lV medical chart, Plaintiffs' #89.* Defendants' affirmative defense was that Phillips failed to inform them of "alleged" prior drug use, and therefore, Dr. Cobb could not diagnose bacterial endocarditis, which is what caused Phillips' death. *Vol. ll p. 944, ln 5-25; p. 945, 1-16; p. 1116, ln 11 thru p. 1118, ln 8; Vol. IV, Agreed pretrial order, p. 6, #7.* This defense was established by the sole fact that Phillips' "allegedly" had checked on the "review of systems" sheet that he did not use drugs. *Vol. lV, medical chart, Plaintiffs' #89.* He did not sign it. *Id.*

Subsequent to no "determination" being made as to Phillips' emergency medical condition, he was referred to make an appointment with the "free clinic", where after, Phillips attempted to gain access to a doctor, via, his sister-in-law Christi Wiseman, and contacted her in an effort to figure out a way to see a doctor. *Vol. II, p. 504, ln 4-21; Vol. I, p. 412, ln 24-25; p. 413, ln 1; p. 414, ln 5-6.* Following his visit to HMC on that fateful Wednesday, Phillips was seen on Saturday by Michael Dacewitz, who described Phillips as driving abnormally, "putting around real slow", "hunched over the steering wheel, clutching his chest" while crying "extremely". *Vol. I, P. 87 ln 11-25.* Phillips died at TRMC on Monday, September 28, 1998, where it is written in that medical chart that Phillips was "seen at another hospital a week previous for similar symptoms." *Vol., I, p. 112, ln 6-24; Vol. IV, medical chart, Plaintiffs' #40.* In the midst of Plaintiffs' contention that Phillips intentionally was not given an "appropriate" medical screening as defined under § 1395dd(a), even HMC did not know how to mask its conduct, when it placed a question mark, (i.e. "?"), under "disposition" of Phillips from its emergency room. *Vol. IV, Disposition of Patient, Plaintiffs' #28.* The question(s) still remain(s): Why was Phillips the only patient with chest pain and a fast heart beat to be triaged to the "minor care" on that Wednesday, on September 23, 1998? Why was Phillips the only patient with a seizure which went to the "minor care" of the emergency room? Why was Phillips the only patient with "weakness" who was triaged to the "minor care"? *See Vol. IV, Plaintiffs' #25, and #26.*

V. SUMMARY OF ARGUMENT

The trial court rolled out the red carpet for the Defendants at trial. Plaintiffs had no opportunity to receive a fair trial because the trial court emasculated Plaintiffs' ability to rebut powerful causation testimony. The trial court ruled effectually that the Defendants could prove that Phillips' disease process, was caused by drug use, (which was not even an issue at trial), and that Plaintiffs could not rebut this. *Vol. I, p. 8, ln 3-15, See Attachement "C".* However, once brought before the jury,

fairness required opportunity to challenge this injected red herring, especially since this causation evidence of Defendants', undeniably caused the jury to believe that Phillips was the sole cause of his own death. This was Defendants' affirmative defense--contributory negligence. Plaintiffs were denied all opportunity to rebut or challenge this decisive evidence and argument by Defendants. It was incredible. Plaintiffs appeal to this Court in bewilderment. That is the iceberg. The tip of which is the trial court's granting of HMC's Rule 50 motion. The sum total of the trial court's efforts, left the Plaintiffs with a negligence claim, confronted by an affirmative defense that was unrebuttable per court order. Defense verdict! Plaintiffs appeal to this Court seeking fairness in jurisprudence and trial advocacy.

VI. ARGUMENTS AND AUTHORITIES

A. The district court erred when it sustained the Defendant's Rule 50 motion and precluded Plaintiffs' EMTALA claim under 1395dd(a) from being submitted to the jury.

The trial court granted HMC's Rule 50 motion at the close of Plaintiffs' evidence, that as a matter of law, no EMTALA claim should be presented to the jury. *See Ruling Attachment "A".* In reviewing the granting of Defendant, HMC's, Rule 50 motion, the Tenth Circuit will apply the same standard, as the trial court is required to apply at time the motion is made. *Finley v. United States*, 82 F.3d 966, 968 (10th Cir. 1996). This means this Appellate Court will review this issue without giving deference to the trial court's decision, and a "denovo" review shall be implemented. *Id.* If after viewing the evidence in the light most favorably for Plaintiffs, the evidence points only "one way", and it is not susceptible to reasonable inferences supporting Plaintiffs, only then may the trial court's ruling stand. *OJA v. Howmedica, Inc., 111 F.3d 782, 792 (10th Cir. 1997). Id.* (citing internal quotations omitted).

Congress enacted the Emergency Medical Treatment and Active Labor Act ("EMTALA"), in an effort to subdue and reduce concern over the increasing number of reports that, as health-care costs rose and third party payments increased greater occupancy, hospitals were refusing to accept or treat patients with emergency conditions if the patient did not have medical insurance. *Correa v. Hospital San Francisco, 69 F.3d 1184, (1st Cir. 1995.) certiorari denied, 116 S.Ct. 1423.*

Plaintiffs sought to prove HMC intentionally decided not to "determine" if Phillips had an emergency medical condition because of his no insurance status, and further failed to treat Phillips commensurate with HMC's own standard procedures, and treated Phillips differently than patients similarly situated. *Appendix Vol. lV, Agreed Amended Pretrial Order, p. 3, #3, #14, #16,* #18, #19. Plaintiffs contended that all Defendants conspired to cover up actual violations of EMTALA and negligence. *Id., at p.5, #40.* Phillips was denied proper medical attention and was referred to make an appointment with a "free clinic" for those who have no insurance, after receiving only token treatment. *Vol. ll, pp. 993 ln 13-25 thru p. 994, ln 1-11.* He died 4.5 days later at HMC's sister hospital, TRMC. *Vol., IV, Plaintiffs' #40.*

To overcome HMC's motion for judgment as a matter of law, Plaintiffs only need to demonstrate the following: 1.) EMTALA applies to HMC; 2.) Phillips sought treatment at HMC's emergency room; 3.) HMC treated Phillips differently than other patients would have been treated in similar circumstances; or, HMC did not treat Phillips in conformity with the hospital treatment policy for patients in similar circumstances; and, 4.) Policies alleged to violate EMTALA were not "de minimus"; and, 5.) There is a causal link between Phillips' death and the way HMC did or did not treat him in this regard; or, only that; 6.) HMC intentionally did not "determine" whether Phillips had an emergency medical condition because of his financial status, regardless of whether policies applicable to Phillips' condition, were de minimus; or, 7.) Even if HMC had no standard procedures applicable to Phillips, if HMC

intentionally did not "determine" whether Phillips had an emergency medical condition because of Phillips' financial status, HMC is liable to Plaintiffs. *Repp v. Anadarko Municipal Hospital*, 43 F. 3d 519, (10th Cir. 1994). *42 U. S .C. A. 1395dd(a).* Plaintiffs agree that EMTALA is not a medical malpractice statute, but submit that an instance of negligence may be present simultaneously with a violation of a hospital policy, which violates EMTALA.[1] *See Power v. Arlington Hospital Assoc., 42 F.3d 851, 858-59 (4th Cir. 1994).*

Some of Plaintiffs' factual inferences are encompassed in the question of whether the personnel for HMC is being truthful in a line of questioning at trial or in the medical chart. Plaintiffs have pursued HMC under EMTALA §1395dd(a) for intentional discrimination based on Phillips status of not having insurance. Although intentional discrimination may not be viewed as an element of EMTALA, intent may be utilized to show the reason HMC's policies and procedures were not followed, or in this instance, even why HMC employees testified what they did. *Reeves v. Sanderson Plumbing Products Inc.*, 503 U.S. ----, 120 S. Ct. 2097, (2000). *See Roberts v. Galen of Virginia, Inc., 525 U.S. 249, 119 S.Ct 685 (1999).*

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[1] We agree with the district court's conclusion below that, "absent such standard protocols," an EMTALA claim may be established through "proof of a failure to meet the standard of care to which the Hospital adheres." Although allowance of such proof potentially blurs the line somewhat between a malpractice claim and and EMTALA claim, they are still distinct causes of action as the following illustration given by district court elucidates: Consider a situation in which a hospital adheres to a standard requiring tests A, B, and C as part of an appropriate emergency room medical screening. In many instances, this standard will also be the malpractice standard of care. Thus, failure to perform test C, for example, would violate both EMTALA and the standard of care applicable in a malpractice claim. But if tests A, B, and C are performed and the doctor evaluating the results draws the incorrect conclusion, a violation of EMTALA may not be established, but medical negligence may be. *Power v. Arlington Hospital Assoc., 42 F.3d 851, 858-59 (4th Cir. 1994), (cites for quotes omitted).*

Most recently, in *Reeves*, the Supreme Court held in reversing the Fifth Circuit in a case involving intentional employment discrimination, that a plaintiff can prove intent by showing that the employer lied about its reason for the firing or demotion and that a jury can infer that the false explanation was a cover-up for the discrimination. *Id at 2112.* In so holding, the Court noted, "Proof that the defendant's explanation is unworthy of credence is simply one form of circumstantial evidence that is probative of intentional discrimination, and it may be quite persuasive." *Id at 2108.* By the same reasoning, Plaintiffs attempted at trial, to show HMC intentionally did not "determine" Phillips' medical emergency, and intentionally discriminated against Phillips because of his "no insurance" status.[2] *Vol. IV, medical chart, Plaintiffs' #89.* Also, that Phillips' medical emergency was not only apparent, obvious and real, but that HMC manipulated and changed documents in an attempt to cover-up Phillips' emergency condition, and that Defendants intentionally did nothing to "determine" if Phillips had an emergency medical condition on his presentation to HMC on September 23, 1998. *Vol. II, p. 734, 1-6; p. 738, 22-25; p. 739,1-3; p. 504, ln 4-21; Vol. I, p. 77, 2-11; p. 81, 11-25; p. 82, 1-7; p. 205, 18-25; p. 206, 1-25.* Vol. IV, #4, *Amended Agreed Pretrial Order, p. 3, #19, p. 5, #40.* Plaintiffs contend HMC would have had to admit Phillips into its hospital if it had not intentionally discriminated and purposely failed to treat Phillips commensurate with his actual presentation. *Vol., IV, Agreed pretrial order, #4, p. 3, #17.* HMC did not want to absorb this financial blow.

Plaintiffs submit to this Court, that if HMC intentionally decided not to "determine" if Phillips had an emergency medical condition under 42 U.S.C. §1395dd(a), the question of whether or not HMC had policies applicable to argue that Phillips was not treated uniformly with those policies, is irrelevant. *See §1395dd(a).* The plain language of this statute

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[2] Vol. IV, #4, Amended Agreed Pretrial Order, p. 3, #19, "Phillips was treated differently based upon his status."

obliges a participating hospital to "determine" whether or not an emergency medical condition exists. *Id.* HMC conceded in the Agreed Pretrial Order it is such a participating hospital. *Vol. IV., Agreed pretrial order, #4, p. 6, F.* Plaintiffs agree that the law is well settled that it is up to the hospital to decide what is within its capabilities under the §1395dd(a). *Repp at 522.* However, upon learning he had no insurance, if HMC intentionally chose not to consider whether Phillips' emergency situation was within its capability, and made the decision, "We will not determine whether you actually have an emergency, nor whether we have the capability to handle your emergency, we are sending you to the "free clinic", in this situation HMC has not met its duty, and is liable. *Correa v. Hosp. San Fracisco, 69 F.3d 1184, 1192 (1st Cir. 1995).*

HMC withheld a crucial piece of evidence from Plaintiffs, which had it been turned over to Plaintiffs, may have only indicated that HMC made a hand written record of HMC's belief that Phillips had no insurance. *Vol., IV, medical chart, Plaintiffs' #89.* Instead, as testified by Plaintiffs' witness Christina Daczewitz, she saw the record which is identified as a HMC face sheet, which contained on it the words "NO INSURANCE", handwritten in cursive, and as she described it, a "ladies" handwriting. *Vol. II p. 780, ln 10-20; p. 781, ln 3-23.* It is HMC's failure to produce this document in the Plaintiff's requested discovery to HMC that lends credence to HMC's culpability. Why would HMC need to manipulate documents unless it was hiding this "NO INSURANCE" reference, other than to ebb away the proof of its intent to avoid following what its policies truly prescribed for Phillips? Plaintiffs' exhibit 12, is an in house policy for shredding face sheets, the exact sheet Plaintiffs' alleged existed and was not provided to Plaintiffs. *Vol. IV, was Plaintiffs' #2, for purpose of appeal see #12.* The jury should have been allowed to infer that HMC, at the very least, conveniently destroyed the document to avoid the unfolding of Plaintiffs' learning the true presentation of Phillips.

Plaintiffs have other evidence probative of document tampering. Plaintiffs' exhibit 45, clearly reveals serious record

manipulation on part of Defendants. *Vol., IV, Plaintiffs' #45.* This piece of evidence is a triage sheet for a male patient, who appears to be triaged as a category III, like Phillips, and much of the documentation appears to be whited out. *Id.* Is this the true triage sheet pertaining to Phillips? Plaintiffs refer this Court to the "Statement of Facts", above, and the plethora of symptoms Dr. Cobb claims to have dictated from two sheets that do not contain the information she dictated, as well as the "Review of Systems" sheet, not signed by Phillips, which established Defendants only affirmative defense in this case. *See Statement of Facts* above *and Dr. Cobb's contradictions in the body of the following text.*

1. <u>No Screening Occurred</u>

Plaintiffs' expert, Dr. Benjamin Zola ("Dr. Zola") concluded, "there is complaint of chest pain...hurting to breath in and out. During the physical exam there is nothing...on the chart that specifically relates to whether or not this patient...there's nothing on the lungs, there's nothing mentioned on the chest to determine whether or not the patient's was actually examined... specific point of pain... If there was going to be pleuretic type pain, then a reason for that pleuretic type chest pain had to be sought out and determined... many things cause pleuretic chest pain...[it] can be potentially dangerous and life threatening ... those were never investigated or commented upon." *Vol. II, p. 504, 4-2; p. 506, ln 18-25.* Dr. Zola further opined, "it's not enough to just list an impression, it actually needs to be investigated and looked into". *Vol. II, p. 510, 1-3.* Plaintiffs submit this evidence for appeal not as an act of negligence, but as evidence for which a jury could conclude that HMC, in the midst of window dressing its documents, intentionally did not undertake to "determine" whether Phillips had a medical emergency, or knew Phillips in fact likely did have an emergency but deliberately chose to render token treatment to place a mask over any EMTALA violation.

The triage sheet indicates Phillips' chief complaint, in his own words, was "chest pain". *Vol. IV, medical chart, Plaintiffs' #89.* In addition, Phillips' "review of systems" sheet

reveals he was dealing with seizures and angina, i.e. (chest pain associated with cardiac problems). *Id., also Vol. I, p. 303, ln 1.* Dr. Cobb's dictation states, "...chest pain since yesterday, and then ignores chest pain again until her impression states, "Pleuritic Type Chest Pain". *Id.* Dr. Cobb makes this conclusory statement at the end of her diction and never again deals with the chest pain issue. *Id.* Moreover, Dr. Cobb not once mentions the seizures. *Id.* As Dr. Zola testified, the chest pain, pleuritic or otherwise, was never investigated and he opined "it's not enough to just list an impression, it actually needs to be investigated and looked into". *Vol. II, p. 504, 4-21; p. 510, 1-3.* Nothing was done to "determine" if the chest pain or the seizures was an emergency condition. *Id.* Dr. Cobb testified that an "EKG", "blood work or blood count", are simple tests easily ordered, and she did none of those, nor any diagnostic testing for the chest pain. *Vol. I, p. 248, 7-23.* All records are absent anything being done for the seizures or even being commented upon. *Vol. IV, medical chart, Plaintiffs' #89.*

Dr. Cobb's own dictation has major credibility issues. Michael Daczewitz testified Phillips had a "fluid sound on his lungs" and it sounded "gargulatous" on the Tuesday before HMC's visit and on the Wednesday in question, and compared it to his mother's walking pneumonia. *Vol. I, pp. 81, ln 1-25; 82, ln 1-7.* Yet, Dr. Cobb's medical dictation, states Phillips' lungs were clear to "ausculation". *medical chart, Plaintiffs' #89.* Dr. Phillip Murta, attending resident physician at HMC's sister hospital, who saw Phillips 4.5 days later just before he perished, testified his initial impression of Phillips was that he had "atypical pneumonia" because of the fluid building in his lungs. *Vol. I, p. 111, 11-13.* Where did this fluid go? Lulka, testified Phillips was "real weak", his "color was real bad", "looked...greenish", he was "sweating", "slumped over", "tears in his eyes...from the pain", at times he was "shaking" from chills, he was in "pain every minute" he was in the emergency room, and would "clench" upon "any movement. *Vol. I, p.198, 20, p. 203, ln: 7, 11, 16, p. 205, 20, p. 206, 11, 15, p. 225, 5, 7.* An emergency medical technician, James Cooper, Phillips' boss, who saw Phillips either the day before Phillips presented

to HMC, or on the same day, testified Phillips looked "very bad, very bad", "real pale, sweaty...like a zombie, like walking dead". *Vol. II, pp. 738, ln 24, 739, ln 2-3.* Mr. Dacezwitz, further testified, that on the Wednesday in question, Phillips was "stuttering" when he talked because the pain was so "tremendous". *Vol. I, p. 77, 2-11.*

Yet, Dr. Cobb's dictation is dramatically different, stating Phillips' is a "well developed, well-nourished, pleasant gentleman" and that "[e]xamination is unremarkable". Dr. Cobb expounds at trial, "I walked into the room and Mr. Phillips was sitting on the exam table. He was sitting there very quietly. He certainly did not --my words would be, he didn't appear to be in any distress." *Vol. I, p. 286, 2-5.* Also, at trial she apparently forgets this testimony on p. 286, and twelve pages later she says, "Mr. Phillips was not feeling well. I mean that was obvious both to me and him, and so for that reason I gave him several days off work...". *Vol. I, p. 298, 14-16.*

Also in her dictation, Dr. Cobb states in the history of present illness: "The neck has been ***stiff*** for nearly three weeks. It is painful to ***try*** to turn it from side to side." *Vol. II, medical chart, Plaintiffs' #89.* (emphasis added). Yet, regarding the neck: "***Full*** movement of neck is noted." *Id.* (emphasis added). It is not consistent to say a person has a stiff neck that it is painful even to try to turn it, and then dictate under physical examination: Neck: "Full movement ...is noted". *Id.* Dr. Cobb appears to have reconstructed the record to mask its original state. Defendants either manipulated the records to rid Phillips' visit of symptoms believed to be inculpating of an EMTALA violation that would be triggered by HMC policies or to mask that Defendants intentionally did not screen Phillips and are now tripping over their own extraordinary contradictions, which occurs when documents are changed. The third possibility is Defendants were just extremely negligent and contradictory, but that is not Plaintiffs' EMTALA claim. Plaintiffs' EMTALA claim goes to intentional conduct. *Vol., IV, Agreed Pretrial Order #4 p. 3, #19.* The question begs, did Defendants, after learning of Phillips' death 4.5 days later,

realize records needed to be changed to simulate compliance with EMTALA after intentionally choosing not to screen Phillips? HMC's medical director, Steven Landgarten, testified at trial that the risk management division of HMC notified him of Phillips' unexpected death at another hospital approximately one week after the occurrence, and a review of Phillips' file was triggered. *Vol. II, p. 682, ln 20, p. 689, ln 12-25.* However, no written report was made. The jury should have been allowed to infer that Defendants changed the records or even manufactured records to mask Defendants' action of intentional discrimination in deliberately choosing not to test Phillips for an emergency medical condition, or to mask a violation which corresponded to a violation of HMC policies which HMC knew it intentionally violated. Let not this Court forget Plaintiffs' exhibit 45, admitted into evidence. *Vol. IV, manipulated triage sheet, Plaintiffs' #45.*

2. Policies Discriminatory and Were Violated

At trial, after testifying that the subject "Triage Manual" was in effect on September 28, 1998, on examination by Plaintiffs, Shanna Delsorbo, the emergency department manager, changed her representation on the witness stand, and began to eliminate disfavorable policies as not being in effect on the date in question. *Vol, I, p. 133, 11-14; 130, 21; 132; 12-17.* For instance, the policy for triage category III* states, "These patients will be ***strongly encouraged*** to accept clinic referral unless they have proof of insurance coverage." *Vol. IV, triage manual, Plaintiffs' #47, p. 6, para. 2) emphasis added.* After stating the "triage manual" was in effect, she stated that this specific one was not in effect at the time. *Vol, I, p. 133, 11-14; 130, 2.* Of course, Plaintiffs' challenge the veracity of Delsorbo as to whether the policy was actually in effect on September 23, 1998 when Phillips presented to HMC's emergency room, and it is a jury question. This policy is evidence of HMC's strong aversion to those without insurance or the ability to pay and this tends to prove HMC's motive and tendency to discriminate. *See Vol. IV, triage manual, Plaintiffs' #47, p. 6, para. 2).*

Phillips is already outside a class that receives preferential treatment. A policy in the HMC "Triage Manual", in affect when Phillips presented, states "All Hillcrest Medical Center employees will be seen regardless of triage category or ability to pay...[t]his will also apply to any employees family members." *Vol. IV, triage manual, Plaintiffs' #47, p. 7, para. 6)., Vol, I, p. 135, ln 12-25; pp. 136, ln 1-25; 137, ln 1-25.* HMC employees and family members will be seen regardless. *Id.* This is per se evidence of HMC's discriminatory practice against Phillips.

a. 7 Tower Central Monitoring of the Emergency Department

The above titled policy, states:

> The decision to place an Emergency Department patient on a cardiac monitor will be made by the Emergency Department physician, the patient's physician, and/or the patient's physician, and/or the patient's responsible Registered Nurse/Licensed Practical Nurse. Cardiac monitoring <u>can be anticipated</u> with patients presenting with the following symptoms/complaints:
>
> [sic, (other symptoms listed)] (emphasis added)
> -Chest pain
> -Seizure
> -Weakness

See Vol .IV, Plaintiffs' #22.

Phillips, according to the medical chart, presented with chest pain/angina (i.e., pain associated with the heart), neck pain, and seizure, along with the weakness testified to by Lulka. *Vol., I, p. 199, 4, Vol. IV, medical chart, Plaintiffs' #89.* Plaintiffs submit the jury was allowed to find this policy was violated when Phillips was not placed on cardiac monitoring. To "anticipate[]", means: to cause to occur prematurely; to act before often with the intent of checking or countering, look

forward to as certain. *Websters Third New International Dictionary, ubd, (1993), p. 94.* HMC violated this policy.

b. Chest Pain/Acute MI, Protocol

Dr. Zola found multiple deviations from HMC policies, including the above captioned policy. *Vol. II, p. 501, 13, 19; 503, 4-8.* Clearly, a patient presenting with the "tremendous" chest pain, with which Plaintiff presented, as well as the seizure and weakness, was a question of fact for the jury. Phillips should have been taken to the cardiac suite and had an EKG, and been placed on a chest monitor within 15 minutes of his arrival according to this policy, as well as had blood work ordered. None of this took place. *Vol. I, p. 248, 7-23.*

c. Nursing Documentation-Patient Reassessment, and Vital Signs

It is the policy of HMC to reassess patients in Phillips' situation prior to discharge or every two hours. *Vol, I, p.396, 2-12; Vol. IV, Plaintiffs' #97, para. 8, (a.) and (c.), Vital Signs para. 7.* It is the rationale of HMC to reassess a patient to catch the possibility of vital sign fluctuations which could be dangerous for the patient. *Vol., I, p. 394, 9-16*; p. 391, 20-25; p. 392, 1-3; p. 394, 4-7; p.396, 2-12. Phillips was never reassessed according to HMC policy.

d. Triage Manual Category

It is the policy of HMC to triage those patients who are sweating (i.e., diaphoresis) and have chest pain to be triaged as an emergency medical condition and would be a triage category I or II. *Vol. IV, Plaintffs' # 47, triage manual, "Criteria for Minor Emergency Patient Treatment, p. "008", letter "o".* In addition, if the person has chest pain and appears ill, that patient is categorized as a category I. *Id., at p. "016".* Phillips was triaged as a category III and sent to the minor side. *Vol., IV, Minor Care Register, Plaintiffs' #26.* A category I and II both are considered emergencies and go to the emergency side of the emergency department. *Vol. IV., Plaintiffs' #47, triage manual,*

p. 4. Plaintiffs presented powerful evidence that Phillips appeared seriously ill. James Cooper, Micheal Dacezwitz, Barbara Hight, and Michael Lulka all saw Phillip just prior to, the same day, or in the emergency room of HMC, and all agree that Phillips looked very ill, and not well. *Vol. I, p. 76, ln 1-11; ln 18-25; p. 61, ln 10-19; p .198, ln 19-25; p. 199, ln 4; p. 203 ln 1-11; p. 205, ln 18-25; p. 206, ln 1-25; p. 225, ln 2-7; Vol. II p. 734, 1-6; p. 738, 22-25; p. 739,1-3.* Cooper, a trained emergency medical technician, characterized Phillips as "very bad, very bad", "real pale, sweaty...like a zombie, like walking dead". *Vol II, p. 733, ln 19-25; p. 738, ln 22-24; p. 739, ln 1-3.*

The jury should have been allowed to decide whether Defendants intentionally made it appear that Phillips had presented as a non-emergency. It is a reasonable inference that Defendants intentionally decided they were not going to "determine", under § 1395dd(a), whether Phillips was an emergency medical condition and at the onset, to avoid the financial blow of admitting Phillips into the hospital, falsely characterized Phillips as a category III, only later deciding once the risk management division learned of Phillips' death, their documentation on Phillips, did not sit comfortably. Now present are bungled records and extraordinary contradictions. *See Dr. Cobb's dictation, discussed above, and Vol. IV., Plaintiffs' #45; Vol II, p. 733, ln 19-25; p. 738, ln 22-24; p. 739, ln 1-3.*

All of these various policies, records and testimony, are evidence supporting Plaintiffs' contention that HMC intentionally chose not to "determine" whether Phillips actually had an emergency medical condition, and have made an effort to cover-up their violations, as well as evidence of the particular violations of the policies submitted. The trial court erred drawing inferences favorable for Plaintiffs and HMC's Rule 50 motion should have been denied. This case should be reversed.

B. The district court committed plain error by admitting allegations of prior drug use of the decedent, Martin Shane Phillips, when it was highly

prejudicial with zero probative value, no relevance and seriously affected the fairness of the trial.

1. EVIDENCE OF DRUG USE IS IRRELEVANT

a. The Drug Evidence Rebutted Nothing In Plaintiffs' Case In Chief

The trial court greatly erred when it allowed Defendants to rebut a negligence case which did not exist. *See Order, Attachment "B"; or Vol. III, begin p. 20, ln 6- p. 33, ln 7.* All evidence by Defendants alleging that bacterial endocarditis is caused by drug use, and Phillips did drugs, and Dr. Cobb needed the drug information to diagnose bacterial endocarditis, addressed nothing Plaintiffs presented or in any way contended. *Vol. IV, #Agreed Amended Pretrial, #4, Plaintiffs' Remaining Contentions, p. 2.* It is entirely irrelevant. Upon examining the events of the pretrial, it is apparent that the trial court's focus was on the belief that Plaintiffs' negligence case had its genesis in Dr. Cobb's failure to diagnose bacterial endocarditis. *Vol., III, #3, p. 10, ln 6-10; p. 20, ln 6-15.* This is not Plaintiffs' case, and the court was allowing Defendants to rebut the crux of this phantom negligence by allowing Defendants to assert an affirmative defense of contributory negligence against Plaintiffs' case, which was not the Plaintiff's case. *Id.* Plaintiffs had always asserted that this was not a case for contributory negligence. *Vol. IV, #6, Objection to Civil Minute.*

HMC treated Phillips for a sprained neck, when in fact on presentation to HMC, as admitted by Dr. Cobb's own expert, he was suffering from a deadly infection on his heart. *Vol. II, p. 931, ln 1-13.* The gist of Plaintiffs' case in negligence is failure to test, not failure to diagnose bacterial endocarditis. *Vol. IV, Agreed Pretrial Order, #4, Plaintiffs' Remaining Contentions, p. 2 thru p. 4.* A real life example of the true issue at trial, is seen by examining the procedure followed by HMC's sister hospital, TRMC, upon Phillips' presentation 4.5 days after being "dumped" by HMC. *Vol. IV, medical chart #40.* Dr. Phillip Murta, the attending resident physician at TRMC testified standard procedure and one of the first things done

when someone arrives appearing ill, (and done for Phillips when he presented on September 28, 1998), is to "draw blood" for lab testing. *Vol. I, p. 109, 5-10.* Once the blood work revealed an incredibly high white blood cell count, a very powerful antibiotic was administered. *Vol., I, p. 111, ln 2-3.* This information was garnered and antibiotics administered even though Phillips denied drug use and there had been no diagnosis of bacterial endocarditis. *Id., also, p. 117, ln 12-15; p. 123, ln 17-24.* This exemplifies Plaintiffs' negligence complaint, that because Phillips presented to HMC with the appearance of serious illness, testing should have occurred, (i.e., at least a blood count should have been done), not that bacterial endocarditis should have been diagnosed. *Vol. II, p. 512, ln 6-14.* Antibiotics could have been administered at HMC, without any diagnosis of bacterial endocarditis, HMC could have treated Phillips for an underlying infection, regardless of the particular bug or its etiology. *Vol. II, p. 512, ln 9-12.* That is Plaintiffs' case.

If these procedures had been done 4.5 days earlier at HMC[3], Phillips would still be alive today, even if Dr. Cobb never diagnosed bacterial endocarditis. *Vol., II, p. 513, ln 6-16.* Dr. Cobb's own expert admitted that Phillips' had the vegetations of bacterial endocarditis on his aortic valve on the day he presented to HMC, and that had a blood count been done on that day it "may have been...slightly elevated". Vol., II *p. 931, ln 13, p. 940, ln 5.* Plaintiffs' negligence case has its genesis in violations of standard of care against Defendants, for failure to test, not in failure to diagnose bacterial endocarditis. *Id.* This is Plaintiffs' negligence case.

Plaintiffs assert that Phillips was actually and obviously seriously ill before, during and after his visit to HMC, that proper examination by Defendants must have indicated that he was seriously ill; that Defendants did not treat him as seriously ill; and

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[3] "The antibiotic is called Rocephin. It is very powerful, it's one of the strongest antibiotics that we have. Sometimes we liken it to using a shotgun to kill an ant. It's a very powerful weapon." *Vol. I, p. 111, ln 2-3.*

that therefore Defendants either (1) negligently failed to notice Phillips was seriously ill, or (2) having noticed, negligently failed to treat him as though he was seriously ill. *Vol., IV, #4 Agreed Amended Pretrial Order, p. 2 - p. 4.*

This Court can easily see, Defendant's failure to diagnose bacterial endocarditis was not the issue. Plaintiffs' expert, Dr. Zola, testified Dr. Cobb did not have to diagnose bacterial endocarditis, she just had to realize he was ill and an investigation of that illness needed to occur by doing a blood count, or admitting Phillips into the hospital, where he would have received antibiotics for an underlying infection. *Vol. II, p. 512, ln 9-12; p. 506, ln 18-25; p.507, 1-3.*

It does nothing for Defendants to argue that Phillips failed to give truthful information about prior drug use, so that Dr. Cobb could diagnose bacterial endocarditis, when Plaintiffs' were not suing her for failing to diagnose bacterial endocarditis. Nowhere in Plaintiffs' pretrial order contentions does this exist. *Vol., IV, #4 Agreed Amended Pretrial Order, p. 2-4.* Defendants' assertion addresses nothing in Plaintiffs' lawsuit. That lawsuit did not exist, and therefore efforts to rebut the same, should not have either. Their argument was irrelevant, and it should not have been admitted. The trial court made a great error.

b. Phillips' Prior Drug History Had No Purpose

Plaintiffs ask this Appellate Court: What is the purpose for the admission of evidence, which has been ruled by the same trial court to be not at issue? There can be none. Yet, the trial court admitted drugs when no purpose existed. The trial court recognized that the actual cause of Phillips' bacterial endocarditis was not relevant and not at issue, and ordered that Defendants could not even suggest that drugs were the cause of Phillips' death or there would be "[O]ld [T]estament stuff". *Vol., I. p. 8, ln 3-14, See Attachment "C"; Vol. II, p. 755, ln 23-25; See Attachment, "D".* So why admit drugs if that evidence goes only to establishing the actual cause of Phillips' bacterial endocarditis? It is clear this is what occurred.

The trial court, in an act of mayhem, endorsed Defendants' contributory negligence defense, all while stating the cause of Phillips' bacterial endocarditis was not at issue. *Vol., I. p. 8, ln 3-14; or See Attachment "C".* The defense of contributory negligence, proffered by Defendants, cannot be separated from proving cause of bacterial endocarditis. Which by the way, contravenes the trial court's ruling which it maintained throughout ten pretrials and the trial that such demonstration was not at issue and irrelevant. *Id.*

To remind this Court, Defendants' affirmative defense for contributory negligence was the following: 1). prior drug use causes bacterial endocarditis, 2). Phillips "allegedly" engaged in prior drug use, 3). Dr. Cobb needed this information to diagnose bacterial endocarditis, 4) Phillips did not give her this information, 5). therefore Phillips died 4.5 days later because he withheld the very information that would have saved his life. *Vol, III, #3, p. 22 thru p. 24, ln 17.* This is causation of bacterial endocarditis and is in direct violation of what the trial court maintained as a ruling was not at issue, nor was it relevant. *Id.* It is preposterous to say it is not. The trial court pretended this was not the reality by making a simultaneous ruling that the parties were allowed to present "potential causes" of bacterial endocarditis, but not the actual cause of bacterial endocarditis in Phillips' case. *Vol., I, p. 8, 1-21; or See Attachment "C"* This effectively emasculated Plaintiffs' ability to rebut Defendants' affirmative defense of contributory negligence.[4]

Defendants cannot establish that Phillips' contributed to this own death, as they alleged, without proving drugs were the cause of bacterial endocarditis. Why not? Because Defendants' argument is "I needed to know of this "alleged" drug use in order to save Phillips' life". *Vol, III, #3, p.22 thru p. 24 ln 17.*

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[4] If Plaintiffs were to respect the trial court's order, (i.e., that no party may attempt to prove cause of bacterial endocarditis), then Plaintiffs hands were tied from rebutting that drugs did not cause the bacterial endocarditis, and thus challenge the Defendant's claim of contributory negligence.

To be relieved of liability in the eyes of the jury, Defendants' contributory negligence argument had to be "drugs were the cause of bacterial endocarditis". To conclude otherwise is to say Phillips did not cause his own death. Defendants cannot rely on such an intervening cause, (i.e., concealing drug use), without showing the intervening cause, is the actual cause of bacterial endocarditis. To assert otherwise is to say the intervening cause, (i.e., concealing drugs use which caused bacterial endocarditis), affords HMC no excuse as to why it did no testing for Phillips, unless it is this intervening cause which caused his death.

The trial court confounding its own ruling is nothing short of reality. Saying Defendants can find a witness who will say Phillips has done drugs in the past, testify to this, have their expert say drugs are a "potential cause" of bacterial endocarditis, Phillips died of bacterial endocarditis, Phillips did not inform Defendants of this "alleged" prior drug use, he therefore contributed to his own death, is somehow not a presentation by Defendants as to the "cause of bacterial endocarditis" defies logic. *Vol. I p. 8, ln 3-14; Vol. II, p. 945, ln 8-16.* For the trial court to fail to recognize that Defendants' contributory negligence defense does not involve the "causation of bacterial endocarditis" is a preposterous confection. Even "Tiny Tim" could not negotiate a tip-toe through such close tulips. Yet, the trial court trudged onward. *Id.*

The cause of bacterial endocarditis is not separable from Defendants' contributory negligence defense, therefore that entire defense was irrelevant and without purpose. Defendants' contributory negligence defense in a nutshell, was causation of bacterial endocarditis. *Vol. I, p. 56, 6-18; p. 41, 1-12.* Even the trial court admits it, albeit through its own contradiction. *Vol. I p. 8, ln 3-14; See Attachment "C".*

c. Drug Evidence Had No Foundation

Not only were Defendants allowed to defend a case that did not exist, with a defense of contributory negligence, which the

court inherently ruled was not at issue, all while there was no purpose for the admittance of drug evidence, Defendants were allowed to claim Phillips was a liar, and a user of "street drugs", who caused his own death, all under the guise of manipulating one document. The "review of systems" sheet. *Vol. IV, medical chart, Planitiffs' #89; or See Attachment "G".* The fulcrum of Defendants' contentions flowing from this one document was based on an unfair, prejudicial, and fundamentally ambiguous question in the context of this case. Defendants contented that Phillips was a liar or at least that he failed to disclose what Dr. Cobb needed. *Vol. III, #3, p. 24, ln 13-16. Vol. I, p. 56; p. 41, 1-12; Vol. II, p. 861, 14; p. 944 ln 5-25; p. 945, ln 1-16; p. 1116, ln 23 thru p. 1118, ln 13.* This in turn hindered any effort to diagnose bacterial endocarditis, (which Plaintiffs never contended she needed to do). *Id.* Defendants' entire contributory negligence defense had no foundation for such assertions in light of this fundamentally ambiguous question.

The extreme and fundamental unfairness of this assertion, gains clarity by grasping the fact that Phillips, in all likelihood, disclosed the truth when he "allegedly" filled out this flawed questionnaire. Plaintiffs contended Phillips never filled out this questionnaire. Plaintiffs remind this Appellate Court, that there is substantial evidence of document tampering, and as argued at trial, Phillips did not sign this questionnaire as is required, where it states "Patient/Responsible Person's Signature". *Vol., IV, medical chart, Plaintiffs' #89; Plaintiffs' #45.* But guess whose signature is there, Dr. Cobb's. *Id.* This document establishes all Defendants only affirmative defense. *Vol. IV, #4 Amended Agreed Pretrial Order, p. 5 para. d, "Finally, Defendants state the patient was comparatively/contributorily negligent in not stating drug use".* Hmmm-- anyhow, assuming Phillips did answer the questionnaire, it is fundamentally ambiguous and it cannot be a foundation to say that Phillips lied or concealed "alleged" prior drug use. *Vol. ll p. 605, 8-11.* The question does not ask about prior drug use, only present drug use. Observe the following: *"Do you use drugs other than those prescribed by a physician?" Vol., IV, medical chart, Plaintiffs' #89; or see Attachment "G".*

HMC located a ninth hour witness, Deborah Williams, whose testimony is highly suspect, to say she saw Phillips do drugs August 1998. *Vol. II, p. 861, 14.* This was one entire month before Phillips' presentation to HMC. *Id, also Vol. IV, medical chart Plaintiffs' #89.* This testimony does nothing to establish that Phillips was using drugs at the time frame or present time that he presented to HMC. Williams claims to have seen a "line" in front of him when she walked in on Phillips and she never saw him inject it intravenously. *Vol. II p. 869 ln 22-23.* Phillips denied drug use at both HMC and again at TRMC, where everyone agrees he was facing death when he presented. *Vol. I p 107 ln 13.*

Even if Williams testimony were true, it proved nothing to establish a foundation for the purpose that Defendants wanted to use it. Defendants were claiming Phillips concealed or withheld the "alleged" prior drug information from Dr. Cobb when he did not answer in the affirmative on the "review of systems questionnaire", to the question: "Do you use drugs other than those prescribed by a physician? Isn't this just another way of asking, "Are you using drugs?" Regardless of how strong the testimony is, testimony that only establishes that Phillips may have used drugs over one month previous is not probative of whether Phillips was using drugs a month later. Phillips very well could have been telling the truth when he "allegedly" filled out the questionnaire on September 23, 1998. Yet, Phillips, his seven year old daughter, Crystal Star Phillips, and his family is left to suffer financially, and otherwise, for the negligence or intentional conduct of a Defendant who gets to utilize an incredibly prejudice allegation of being a user of "street drugs" and a liar, when he was very likely neither, all because the court made a fundamentally ambiguous question the biggest issue at trial. Allowing this question to be an issue at this trial is so incredibly unfair that it attacks the heart of justice.

Although it was argued to the trial court, and this trial court had been previously reversed by this Court in an analogous issue, the trial court chose to stay its course. *Vol. III p. 48 ln 19-*

25, p.49. In *United States v. Farmer, 137 F.3d 1265, 1270 (10th Cir. 1998),* this Court, decided where a defendant was charged with perjury, that where a question admits of two reasonable interpretations, there must be some evidence to show what the question meant to the person who answered the question which formed the basis of the perjury claim, and without such evidence, only by surmise and conjecture could a jury conclude that a defendant understood the question. *Id.* Before reaching this conclusion, this Court defined a question as "fundamentally ambiguous when it 'is not a phrase with a meaning about which men of ordinary intellect could agree, nor one which could be used with mutual understanding by a questioner and answerer unless it were defined at the time it was [asked]'". *Id at 1269, (internal cite omitted).*

Not one person, including Phillips, could testify what the question meant to him at the time he "allegedly answered it. *Vol. II p. 605, 8-11.* Under, *Farmer*, the trial court committed unfairness when it allowed this question on the questionnaire to be the fulcrum of Defendants' defense. *Id.*

If allowed to stand, according to Defendants, if Phillips truly did not use drugs, his only hope was to lie and be on notice that he needed to lie and say he was a drug user in order to get the help he needed. In broad application, accordingly a patient who actually has bacterial endocarditis, who actually got it from a source other than drug use, and who in fact never used drugs, walks into an emergency room begging for help, doctors cannot be expected to tell whether he is seriously ill (let alone suspect that the cause of his illness is bacterial endocarditis) unless the patient gives them false information--that he used drugs, even when he didn't. Plaintiffs' negligence cause was not directed toward Defendants' ability to determine Phillips had bacterial endocarditis, so in Phillips case this standard is even more oppressive. This question on the questionnaire was ruthlessly unfair, ambiguous and had no foundation. Under fairness alone it should have been excluded, but this Court may rely on *Farmer.*

d. Dr. Cobb Would Not Truly Utilize This Prior "Alleged" Drug Use

This questionable questionnaire is so important to Dr. Cobb, she states: "Well that sheet of paper is not going to change my evaluation. I will go evaluate the patient and listen to his description of the chest pain and of course no matter what-- which one of those they mark I'm going to go evaluate the patient. *Vol. I, p. 316, 22; 317, 1.* This document was not relevant to Dr. Cobb's evaluation, yet it is the entire basis for Defendants' drug testimony. . *Vol. IV, #4 Amended Agreed Pretrial Order, p. 5 para. d, "Finally...".* Therefore, this document had no value in Defendants' theory of affirmative defense. Defendants concocted this argument, it is all they had.

2. ADMITTING DRUG TESTIMONY WAS PLAIN ERROR

a. *It Was Highly Prejudicial*

The trial court recognized that evidence of Phillips' "alleged" drug use could be highly prejudicial. *Vol. III, #5, p. 35 line 3.* At pretrial conference, in considering whether to admit such evidence, the trial court stated, "I don't believe in drive-by character assassination". *Id.* Regarding drugs, the jury heard from Defendants' counsel at opening argument; it recurred in testimony throughout the trial; and it was the last thing the jury heard from Defendants' counsel in closing argument. *Vol. I, p. 56; p. 41, 1-12; Vol. II, p. 861, 14; p. 944 ln 5-25; p. 945, ln 1-16; p. 1116, ln 23 thru p. 1118, ln 13.* The drug testimony allowed the Defendants to assert that Phillips withheld the information that would have saved his own life. *Id., see also Attachment "B", p. 24.* It "appears" that Phillips, checked "no" to the question: Do you use drugs other than those prescribed by a physician? *Vol. IV, TRMC medical chart, Plaintiffs' #89; or See Attachment "G".*

This powerfully implies Phillips lied, especially in light of the testimony of Dr. Murta, who testified he expected drug users to deny drug use. *Vol, I, p. 117, ln 5.* The jury could not help but

infer that Phillips likely concealed this information. Prior drug use, plus concealing drug use, for the Defendants would gain a lot of sympathy for Dr. Cobb. Phillips was dead and could not refute the powerful testimony and implication. This evidence extremely prejudiced the Plaintiffs' case, and "assassinated" Phillips character in a drive-by. In the eyes of the jury, Phillips was not only a druggie but a liar, who deliberately withheld information from his doctors; and that his surviving family members were mere opportunists seeking to line their pockets at the expense of medical personnel laboring under hopeless misdirection.

b. It Was Very Confusing

Defendants' affirmative defense for contributory negligence was the following: 1). prior drug use causes bacterial endocarditis, 2). Phillips "allegedly" engaged in prior drug use, 3). Dr. Cobb needed this information to diagnose bacterial endocarditis, 4) Phillips did not give her this information, 5). therefore Phillips died 4.5 days later because he withheld the very information that would have saved his life. *Vol., II, p. 1116, ln 11 thru p. 1118, ln 8.* The jury could not help but infer that drug use causes bacterial endocarditis, and that failure to disclose drug use causes misdiagnosis of bacterial endocarditis; Phillips caused his own death. Defendants' defense as presented does not make sense any other way. In fact, Defendants' defense does not make sense; but the jury did not know the full absurdity of it--i.e., that according to Defendants the words "drug use" will change a diagnosis from "sprained neck" to "heart failure", and that a doctor needs to know about drug use to find bacterial endocarditis even if the drug use did not cause the bacterial endocarditis, and Defendants needed to present this even if it did not rebut Plaintiffs' case in chief. It was confused the jury and led them away from the true issue: Did the Defendants fall below the acceptable standard of care when they did nothing for Phillips in light of his seriously ill appearance? If a person shot their self in the head and they are bleeding profusely, a medical provider does not need the etiology of that to know to admit the patient into the hospital. Instead, the jury was left thinking "the drug evidence is critical to this case". That is confusing.

c. It Was Plain Error

Plain error is limited "to errors which seriously affect the fairness, integrity or public reputation of judicial proceedings." *McEwen v. City of Norman, Oklahoma*, 926 F.2d 1539, 1545 (10th Cir. 1991) (quoting *Karns v. Emerson Elec. Co.*, 817 F.2d 1452, 1460 (10th Cir. 1987)). It is plain that the introduction of drug testimony and all of Defendant arguments flowing from the questionnaire, miscarried justice in this case. This evidence rebutted nothing in Plaintiffs' case in chief. The Defendants argument for this evidence was a concoction so confusing. it confused and confounded the trial court into violating its own order: Actual cause of bacterial endocarditis is not at issue. *Vol. I, p. 8, ln 3-15.* This was a web of mayhem, exacerbated by the ambiguous question: Do you use drugs other than those prescribed by a physician. How can justice not be miscarried when Defendants are allowed to present defenses that do not address a Plaintiff's case in chief? Justice was miscarried when this occurred by the shear weight of the evidence against fairness to the Plaintiffs. The Defendants only affirmative defense was the presumed fact that Phillips was untruthful on a questionnaire that was fundamentally ambiguous. This one question, which Phillips, from his grave could not rebut, left Plaintiffs with one option, to disprove a negative. That is impossible, unless the Plaintiffs could prove on September 23, 1998, that the entire planet was absent non-prescription drugs. This one question, trapped the Plaintiffs, and granted the Defendants free reign at trial to continually call Phillips a liar by implication and innuendo. If Phillips were alive, he could have testified what the question meant to him, and even if he admitted he did drugs even three days prior to answering the question, he could still admit that and explain the question to him was not time specific and that he had decided the day before to quit using drugs. At least then he is not a "liar". The Defendants needed testimony that Phillips did drugs on the day in question or much closer in time than one month earlier. Miscarried justice and plain error must be present, and was present where the trial court's ruling in the same act,

allowed a false defense to powerfully attack the credibility of Plaintiffs' case, while tying Plaintiffs' hands behind their backs. The jury could not help but believe it was Phillips dishonesty that caused his own demise. *Vol. III, #3, p. 24, ln 13-16.* The trial court committed "plain error".

C. The trial court abused its discretion, and in doing so committed plain error that went to the integrity of this trial when it was one-sided in allowing all Defendants to present evidence and argument that Phillips' bacterial endocarditis was caused by drug use, but overruled Plaintiffs' attempt to rebut this evidence and argument by the Defendants.

1. ERROR FOR ABUSE OF DISCRETION THE TRIAL COURT ERRED AND ABUSED ITS DISCRETION

Plaintiffs offered the testimony of Dr. Benjamin E. Zola that, within a reasonable degree of medical certainty, Phillips' bacterial endocarditis was NOT caused by drug use, the trial court refused to allow Dr. Zola to so testify on this subject. *Vol. II, p. 751, See Attachment "E".* The trial court declared that "nobody...know[s]" the actual cause, and ruled that cause was not at issue and the parties were not allowed to address it. *Vol. I, p. 8, 12.* The trial court stated that the "universe of...potential causes" should remain "open for [evidence and argument]", *Id. lines 12-14.* The trial court substituted its own opinion for Dr. Zola's medical expertise. To conclude no one knows the cause of Phillips' bacterial endocarditis contradicts Dr. Zola's proffered testimony. *Vol. II, p. 751, See Attachment "C ".* The effect of this ruling was to roll out the red carpet for Defendants and pull the rug out from under Plaintiffs, on the same issue--causation. Defendants' were allowed to put on an affirmative defense for contributory negligence, all while the trial court's ruling would not allow Plaintiffs to rebut it. It was incredible. The jury heard: 1). Prior drug use causes bacterial endocarditis, 2). Phillips "allegedly" had prior drug use, 3). Dr. Cobb needed this information to diagnose bacterial endocarditis, 4) Phillips did not

give her this information, 5). Therefore, Phillips caused his own death. *Vol. lll pp. 32, 33, 34 ln 1-2; Vol. I, p. 56, 6-18; p. 41, 1-12.* This is nothing short of "drugs causing bacterial endocarditis". *Id.* It had a "red carpet" effect. Defendants you claim it is all Phillips' fault, and Plaintiffs you cannot rebut that. Defense verdict!

This is causation testimony, causation argument, and causation inference, totally contravening the trial courts' ruling. Vol., I, p. 8, ln 3-21; or *See Attachment C.* But it is unfairly one-sided, since Plaintiffs were not allowed to present Dr. Zola's testimony, which was offered at trial to rebut Defendants' affirmative defense. *Vol. II, p. 531 ln 4-25; p.532 ln 1-10; p. 752, begin at ln 17; or See Attachment E.* Dr. Zola would have testified that to a reasonable degree of medical certainty, Phillips' disease process was not caused by the use of drugs due to the location of the vegetations on Phillips heart. *See Attachment "E".* This would completely rebut Defendants' assertion that Phillips caused his own death, and it would have reminded the jury that knowledge of prior drug use is not "necessary" for a correct diagnosis of bacterial endocarditis, (even though this was not Plaintiffs negligence claim). In many cases, *including this one*, drug use is not the actual cause of the disease.

Exclusion of expert testimony is reviewed for abuse of discretion, *City of Hobbs v. Hartford Fire Ins. Co.*, 162 F.3d 576 (10th Cir. 1998). In refusing to allow Dr. Zola to testify to the actual cause of Martin Phillips' bacterial endocarditis, the trial court substituted its own expertise for Dr. Zola's, withheld competent and material evidence of a relevant fact necessarily placed in controversy by the nature of Defendants' defense, and misled the jury by allowing Defendants to present evidence powerfully implying causation without allowing Plaintiffs to present evidence which would have decisively rebutted such implication, including Defendants' contributory negligence defense. This was an abuse of discretion and this case must be reversed.

2. ADMISSION OF IRRELEVANT, PREJUDICIAL TESTIMONYAND EXCLUSION OF DR. ZOLA'S REBUTTAL TESTIMONY WAS PLAIN ERROR

In civil cases, review under Fed. R. Evid. 103(d) is limited to "errors which seriously affect 'the fairness, integrity or public reputation of judicial proceedings'", *McEwen v. City of Norman, Oklahoma*, 926 F.2d p. 1545 quoting *Karns v. Emerson Elec. Co.*, 817 F.2d 1452, 1460 (10th Cir. 1987) quoting in turn *Aspen Highlands Skiing Corp. v. Aspen Skiing Corp.*, 738 F.2d 1509, 1516 (10th Cir. 1984) and *Rowe International, Inc. v. J. B. Enterprises, Inc.*, 647 F.2d 830, 835 (8th Cir. 1981). Here, the trial was made one-sided, prejudicial and unfair. Accordingly, the trial court's exclusion of Dr. Zola's testimony should be reversed, and the matter remanded for new trial.

The substantial rights of Plaintiffs were violated when the trial court forbade Plaintiffs' counsel to address the actual cause of bacterial endocarditis and the trial court erred when it threatened mistrial if Plaintiffs even tried to clear the air on the causation issue. *Vol. I, p. 532, ln 2-* . The trial court further erred when it allowed irrelevant testimony by Defendants which manipulated the thought process of the jury, causing them to assume Phillips died at TRMC because of undisclosed drug use, 4.5 days earlier when Dr. Cobb saw him. *Vol. I, p. 56, ln 6-18; p. 41, ln 1-12; Vol. II, p. 944, ln 5-25; p. 945, 1-16; p. 1116, ln 11 thru p. 1118, ln 8.*

A fact in evidence and agreed upon by Dr. Cobb's own expert is that Phillips presented to HMC with the same infection that he died of 4.5 days later, and that a simple blood count would have revealed that infection process. *Vol. II p. 931 ln 7-13.*

The weight of the evidence in this case, reflects that the jury was manipulated by irrelevant and misleading information. *All of Vol. I and Vol. II.* The false defense to a cause of action, which was not part of this litigation served merely to confuse the jury and mock justice.

The question remains upon evaluation of this trial: How can there be justice if Defendants can put on a defense, which has nothing to do with the causes of action being presented by Plaintiffs? Further, what is to happen to the reputation of this court system if Plaintiffs are prevented from rebutting the false defense. Because the diagnoses of bacterial endocarditis was not a cause of action, the failure to diagnose it, should not have been allowed to be defended. *Vol., IV, #4 Agreed Pretrial Order, p. 2- p.4.* The trial court therefore erred.

The trial court erred again, when it refused Plaintiffs the right to rebut Defendants' false affirmative defense with expert testimony and medical records to show that the drug use, if any, had nothing to do with the infection this young man died of. *Vol. II, p. 531 ln 4-25, 532 ln 1-10, Vol. IV, medical chart, #89.* Plaintiffs' substantial rights to a fair trial were denied when the trial court opened the door to this mayhem of confusion. Defendants were granted a verdict in a case which was not on trial. This case must be overturned to preserve the integrity of fair play and even handed advocacy and allow Plaintiffs a day in court which considers the integrity of jurisprudence. Anything less, blackens the eyes of those in the black robes.

D. The district court abused its discretion when it did not allow Plaintiffs to cross-examine the hospital's triage nurse, Lugenia Cue, on Plaintiffs' exhibit No. 25, 26, already admitted into evidence.

At trial, the court ruled that Plaintiffs could not cross-examine HMC's triage nurse, who triaged Phillips to the "minor care" side of the emergency department, as to the specifics behind why other persons with similar complaints were triaged to the "emergency room " of the emergency department, but limited the examination only to whether more patients with chest pain, typically go to the emergency room. *Vol I, p. 371, ln 22; p. 375, ln 25; p. 376, ln 1-25; See Attachment "F".* A discussion was had and the court noted Plaintiffs' objection. *Id.*

If the trial court had allowed Plaintiffs to cross examine Cue on these documents already in evidence, *id.*, it would have shed light on the following questions: Why was Phillips the only patient with chest pain and a fast heart beat to be triaged to the "minor care" on that Wednesday, of September 23, 1998? Why was only Phillips and one other patient triaged to the "minor care" with chest pains, when nine (9) with chest pain (one with chest pressure), went to the "emergency room"? Why was Phillips the only patient with a seizure which went to the "minor care" of the emergency room? Why was Phillips the only patient with "weakness" who was triaged to the "minor care"? *Vol. IV, Plaintiffs' #25 and Plaintiffs' #26.*

To be admissible, any particular item of evidence need not conclusively prove a fact, but must only advance the inquiry in some degree, or have some tendency to make the fact more probable. *2 Weinstein's Federal Evidence (1999) § 401.04[2][b] citing U.S. v. Haar, 931 F.2d 1368, 1374 (10th Cir. 1991).* Here, Plaintiffs' evidence corroborates Plaintiffs' contention that Phillips was treated differently than those in similar medical circumstances, in an effort to prove their EMTALA claim. *See Vickers v. Nash Gen. Hosp., 78 F.3d 139,144 (4th Cir. 1996),* (holding that "EMTALA is implicated only when individuals who are perceived to have the same medical condition receive disparate treatment; it is not implicated whenever individuals who turn out in fact to have had the same condition receive disparate treatment").

The trial court abused it discretion and did not allow Plaintiffs to prove their case regarding highly relevant evidence. This case must be reversed to allow Plaintiffs to prove their case.

VII. CONCLUSION

The trial court made manifest errors of prejudice against the substantial rights of the Plaintiffs, which affected the trial to such proportion that from the beginning of trial, Appellants bore a yoke of such inequality, a "red carpet affect", escorted HMC

to victory lane. Integrity of even-handed advocacy dictates a resolution in favor of the Appellants.

VIII. STATEMENT FOR ORAL ARGUMENT

Appellants request oral argument, because this case involves highlighting and rightly dividing the order of the trial court precluding the Plaintiffs from rebutting the powerful implications of the trial court's granting of Defendants' affirmative defense of contributory negligence, which has seemed very strenuous to concisely express in writing. *See Attachment "C".* It would likely be helpful to provide a presentation. This same rationale is present in the desire to walk this Court through the maze of documents supporting the Appellants objection to the trial court's granting of HMC's Rule 50 motion.

WHEREFORE, above premises considered, Appellants pray this Honorable Court, grant Appellants oral argument and reverse the decisions of the trial court consistent with the issues presented herein, or alternatively, merely reverse the trial court's decisions, while suppressing the drug evidence and reinstating the Appellants as Plaintiffs in this cause.

Respectfully submitted,
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CERTIFICATE OF WORD LIMIT

I, Gregory V. Copeland, as the attorney for Appellants, hereby certify that this brief complies with Rule 32(a)(7(B)(i) in that the word limit for this brief is less than 14,000 words and is exactly, 12,504 words, including footnotes, this certificate and mailing certificate.

/s/ Gregory V. Copeland

Gregory V. Copeland

Certificate of Mailing and Dispatch
To the Clerk of the Tenth Circuit

I, Gregory V. Copeland, certify that on July 28, 2000, and pursuant to **Fed. R. P. Rule 25**, I caused to be mailed in the U.S. Mail with the proper postage thereon, and dispatched an exact copy of the foregoing document to the following:

Clerk of the Court
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Waived mailing and requested to pick up on Monday morning
July 31, 2000

/s/ Gregory V. Copeland
Gregory V. Copeland

The following Attachments have been omitted from this brief but those pertinent may be located within this appendix at the page indicated or are referenced at the end of the Appellants' Petition for Panel Rehearing, which begins on the next page of this Appendix.

ATTACHMENT "A" Court's Order Granting Defendant's Rule 50 Motion.....App 21

ATTACHMENT "B" Court's Granting of Defendant's Affirmative Defense at Pretrial Conference, November 12, 1999.....App 271

ATTACHMENT "C" Court's Ruling Denying Plaintiff's Ability to Rebut Defendant's Contributory/Comparative Negligence Defense.....Omitted

ATTACHMENT "D" Court's Acknowledgement That Cause of Bacterial Endocarditis, ie., Drugs Causing Death Will Invoke "Old Testament Stuff" At Trial.....Omitted

ATTACHMENT "E" Plaintiffs'Offer of Proof For Dr. Zola's Testimony to Rebut Defendants' Affirmative Defense At Trial.....Omitted

ATTACHMENT "F" Plaintiffs' Objection to the Court's Denial of Cross Examination of Hillcrest's Triage Nurse as to Why Phillips Was Placed on the Minor Side of The E.R. and Others went to The Emergency Side at Trial .....Omitted

ATTACHMENT "G" The Questionable Questionnaire .....see Supp. App...20

Case No. 00-5013

IN AND FOR THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

CRYSTAL STAR PHILLIPS, individually, and	)
As next of kin to Martin Shane, on behalf of	)
THE ESTATE OF MARTIN SHANE PHILLIPS	)
By and through her mother, legal guardian and	)
Next friend, MINNIE CHRISTINA	)
DACZEWITZ, and FRED MARTIN PHILLIPS	)
JR., parent of Martin Shane Phillips	)
	)
the Appellants,	)
vs.	)
	)
HILLCREST MEDICAL CENTER, an	)
Oklahoma corporation doing business in the	)
State of Oklahoma,	)
the Appellee.	)

On Appeal from the United States District Court
For the Northern District of Oklahoma

The Honorable Sven Erik Holmes
District Judge

U. S. District Court Case No. 98-CV-829

APPELLANTS' PETITION FOR PANEL REHEARING
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COME NOW, Appellants, eight-year-old Crystal Star Phillips, the Estate of Martin Shane Phillips, and Fred Martin Phillips, Jr., pursuant to Fed. R. App. Proc. 40, and submit their Petition for Panel Rehearing.

I. INTRODUCTION

This Court, in *Phillips v. Hillcrest Medical Center,* 2001 WL 200187, ---F.3d---, (10th Cir.(Okla.)), while addressing Appellants' claims presented to this court, entirely misapprehended Appellants' legal arguments, overlooked and did not address an entire argument addressed to this court, and further, even misunderstood or misconstrued crucial facts which according to this court's present holding and findings, determined the outcome of this case for appeal. *See fn. 3.* In addition, in construing *42 U.S.C. § 1395dd(a),* this court violated the doctrine of separation of powers, with its newly articulated "perceived" standard for EMTALA liability. These propositions are laid out herein, specifically.

IV. APPELLANTS' EMTALA CLAIM WAS MISAPPREHENDED, AND THE LAW WAS MISCONTSRUED SO AS TO VIOLATE SEPARATION OF POWERS

A. This Court Misapprehended Appellants' EMTALA Arguments and Facts

This court misapprehended Appellants' EMTALA claim when it stated:

> 1.) "[A]ppellants' counsel reluctantly conceded HMC, either through Nurse Cue and/or Dr.Cobb, did in fact make a determination as to Phillips' condition with respect to each and every allegation of failure to abide by existing policy requirements." *Phillips at p. 4.*

2.) "Appellants argued to the district court, as they have here, that evidence of a bias towards those who are uninsured is sufficient to state an EMTALA claim."[5] *Id.*

3.) "They argue HMC staff failed to appropriately identify and/or appreciate the gravity of Phillips' condition.[6] In other words, while they concede HMC technically complied with their preexisting standards, the practical effect was an inadequate examination." *Id.*

***i.)* Addressing the "conce[ssion]"**

Bearing directly on the outcome of this court's decision,[7] this court erroneously concluded that concessions were made as to "each and every allegation of failure to abide by existing policy requirements", even in light of the fact that the trial court did not allow the Appellants to be fully heard in response to Hillcrest Medical Center's ("HMC") Rule 50 motion[8]. *See Attachment "T". Id. Also see Phillips at 2* (stating

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[5] Appellants never argued bias was sufficient to state an EMTALA claim. See arguments, *infra.*

[6] This court confused the EMTALA claim with the Appellants' negligence claims. Appellants utilized the facts that HMC "failed to identify and/or appreciate the gravity of Phillips' condition", in their negligence cause, and as an intentional act in the EMTALA claim. Appellants never argued "the practical effect was an inadequate examination" in either cause of action. In negligence, such concept was a direct cause of death.

[7] This court found, "while they concede HMC technically complied with their preexisting standards, the practical effect was an inadequate examination. EMATLA was not designed for such a claim." *See Phillips at 4.* As clarified *infra*, Appellants never conceded their allegations and this court utilized this erroneous finding to pin it to this court's erroneous determination that Appellants somehow argued in the EMTALA claim, "the practical effect was an inadequate examination". This is entirely misapprehended. *See argument at B. subparagraph ii, p. 5.*

[8] Upon inviting Appellants' to explain their points, the trial court would rapidly veer off with its own agenda by requiring response to one of its questions, or cutoff the Appellants. *Vol. II, p. 837, ln 24- p. 838, ln 3; p.*

"a trial judge may grant a motion for judgment as a matter of

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843, ln 3-8. See also, Id. at p. 847, ln 5- Mr. Copeland: "May I answer this question after I explain what the plaintiffs' theory of the case is?" *The Court*: "Well, your in a Rule 50 Motion. The question is. . . [infinitum]. . ." The trial court maintained this attitude even after having been told emphatically by Appellants' counsel, "Your Honor, there are other policies [to be presented] but that's alright[!]" *Id. at 852, ln 7.* Appellants attempted to argue to the trial court, but were told to "amplify [your record] many pages over in Denver". *Id. at 852, ln 3.* The trial court appeared to take this position either because it believed that all evidence of Appellants' allegation that Phillips was intentionally denied treatment because of no insurance, had to come from Mr. Lulka (the witness present at the time insurance information was taken by HMC), or from someone else present while the insurance information was taken by HMC, or because the trial court thought the "perceived" standard, now articulated by this court, means if medical personnel just say they "undertook" to determine a medical condition, it must be taken as true. *Id. at 847, ln 2-4*; Id. at 850, ln 6-7. The following explains how the trial court was adopting a "perceived" standard that relegated all power of what is held as true to the medical personnel of HMC. *(Mr. Copeland:* "Okay. This is where the Plaintiffs adamantly take issue with the Court that the Court is, we believe is making a wrong conclusion under the law, if we could explain. *The Court*: All right. Have you read Repp vs. Anadarko." *Mr. Copeland*: "Your Honor, . . . it's very clear and it is in our trial brief, is that they don't get to get out of an EMTALA claim by coming up here and giving testimony to explain away what they do. In other words, there would never be an EMTALA claim that could ever be brought in a court of law that could be sufficient if a witness can get up and say, oh, I undertook to do that, oh, I undertook to do this. . ." *The Court*: "...I beg to differ sir. If the uncontroverted evidence establishes that in fact they undertook to do all of those things, then [sic] there would not be an EMTALA claim...") *See Vol. II, p. 844, ln 9- p.845, ln 3.* In the eyes of the trial court, "uncontroverted evidence", means to take as true hospital personnels' versions of events. It is apparent that this is what this "perceived" standard means if both the trial court and this appellate court can overlook four independent witnesses' testimony, establishing, if not at least controverting, that Phillips appeared acutely ill and thereby triggered violations of HMC policies. Regarding Mr. Lulka's testimony, the trial court admitted the evidence was that Phillips looked very ill. *Vol. II, p. 903 ln 5-6. (See evidence used for intentional theory, not negligence, Vol. II, p. 848, ln 20-22)(Also see, infra, p. 6, at no. 4)*

law if, after a party has been fully heard on an issue...")(citing *Tyler v. Re/Max Mountain States, Inc., 232 F.3d 808 (10th Cir. 2000)*. Neither were all policy violations allowed to be presented, nor were reasonable inferences of HMC's intentional refusal to treat Phillips allowed to be argued.[9]

Appellants never conceded reluctantly or otherwise, that HMC "did in fact make a determination as to Phillips' condition...", with respect to any, much less, to each and every of Appellants' allegations that HMC failed to follow its own policies and procedures. *See affidavit of Appellants' counsel Attachment "J"*. This court's conclusion that Appellants conceded points is taken dramatically out of context by this court. This court refers to the following cites in its opinion: "*See Vol. II, p 829, ln. 19-20; Id. at p. 830, ln. 11 - p. 831, ln. 4; Id. at p. 831, ln. 5 - p. 832, ln. 4; Id. at p. 843, ln. 11 - p. 844, ln. 12.*" *Phillips at 4*. When being asked by the trial court if HMC personnel undertook to make a determination as to the medical condition of Phillips, all responses by Appellants' counsel such as, "it seems like she did...", were merely noting the fact that this was the argument put forth by the HMC employees or staff and **not** that this is what Appellants concede the undisputed evidence showed. (*See affidavit of Appellants' counsel Attachment "J",)(See also, Vol. II, p. 828, ln 12-18,* contextualizing the responses: **The Court**: "And the testimony, the sole testimony was he did not appear acutely ill; right?" **Mr. Toon**: Well, that's not entirely accurate. I think that's a factual issue, Your Honor, because... [o]f course the people from Hillcrest indicated that he didn't appear that way,...")(*See also Vol. II, p. 848 ln 20-22*, "And Lugenia Cue mistriaged him and put him into Category III... [t]hey cannot

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[9] The trial court would not hear argument on three policies, (*See footnote 4)*, which among others, Appellants presented for appeal: *exhibit 18; exhibit 47, p. 016; exhibit 22, p. 0369, (ex. 2 at trial)*; *Vol. IV*. In addition the trial court did not consider the plethora of evidence in favor of Appellants supporting their theory that HMC intentionally miscategorized Phillips as a non-emergency to avoid its duty to admit him into its hospital. *See evidence, p. 5.*

avoid an EMTALA violation by merely miscategorizing someone on purpose.")

Further, the trial court in its ruling on the Rule 50 motion hung its hat on the fact that Appellants' medical expert, Dr. Benjamin E. Zola, allegedly on cross examination, established that HMC's personnel "undertook to comply with [HMC polices]". *Vol. II, p. 851, ln 15-19.* Appellants expert did nothing of the sort. The Appellants, even through its expert, merely admitted that evidence put forth by HMC personnel was that Phillips did not appear ill. For instance, on cross examination by HMC of Dr. Zola; Q: "Okay. So the triage nurse, according to what she perceived of the patient's situation, clearly met this criteria for minor care admission; correct?" A: "Based on the information that she either believed and/or **recorded**, yes." *Id. at p. 627, ln 9-13 (emphasis added).* These type of answers by Dr. Zola do not establish that the "triage nurse" undertook to comply with HMC policy, but to the contrary make the blaring statement that the "triage nurse" potentially only "recorded" on the medical chart what HMC wanted other eyes to see.[10] This is **not** testimony that Dr. Zola believed legitimate acts were taken by HMC but to the contrary. Further, Dr. Zola's statement at *Vol. II, p. 631, ln 22,* was not a concession that he believed the triage nurse "thought" Phillips did not appear ill, it was only a statement agreeing he and HMC's counsel

[10] To further contextualize what Dr. Zola's position was regarding the recorded symptoms found in Phillips' medical chart, in regard to Dr. Cobb, Dr. Zola testified, "I don't find that credible given the number of witnesses that testified as to what Mr. Phillips' condition was in the days before and even the moment and even during leading up to his emergency room evaluation. Those depositions including witnesses that were not necessarily his friends or acquaintances or anyone with a vested interest in perhaps describing him as being sicker than he actually was." *Id. at p. 597, ln 15-21.*

had already discussed what the triage nurse had recorded about Phillips' appearance.[11]

ii. Evidence Controverted HMC's Assertions That HMC Did Not "Perceive" Phillips' Ill Appearance

Appellants' theory was that HMC purposely miscategorized Phillips as a non-emergency patient and attempted to mask their decision not to treat Phillips' true physical presentation, so as to avoid the additional costs, by purposely minimizing his symptoms in the medical chart, including changing documents once HMC learned Phillips died at its sister hospital, so as not to leave evidence of policy violations. The strength of Appellants' case is overwhelming. Appellants have submitted enough controverted evidence in their Opening and Reply brief, as well as here, to demonstrate the facts do not "point just one way." *See Finley v. United States, 82 F.3d 966, 968 (10th Cir. 1996).*

1. Barbara Petty, Hillcrest nurse, at *Vol. I, p. 392 ln 2*, regarding the policy for rechecking vital signs when asked: Q. "Did you follow that policy? A. "I DID NOT....." Q. "Okay. That should have been done; right?" A. "YES." *Id. at 396 Ln 6-7. See policy, Attachment "S".* The trial court admitted this policy was violated. *See fn 15.*

2. When asked, "Does Hillcrest require you to follow written policies and procedures in the emergency department? Dr. Carolyn Cobb said, "No." *Vol. I, p. 242, ln 9.* HMC has a total non-accountability to EMTALA in that policies are not required to be followed. This tends to prove they did not follow their polices regarding Phillips.

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[11] Q: "Okay. If that nurse in her judgment did not think the patient [was] acutely ill, then number D doesn't apply in this case, would you agree with that?" A: "No, that's not necessarily true. [sic] Based on what she has listed there's nothing in the medical records to imply that she had anything to go on that he was acutely ill with the exception of the pulse rate of 112 which has been unexplained." *Vol. II, p. 623, ln 11-20 (contextualizing Id. p. 631, ln 22.)*

3. Three lay witnesses and an emergency medical technician observed Phillips' extremely ill condition, during, just prior to his visit or on the same day as Phillips visit to Hillcrest. Three of them within one hour before, *(Daczewitz, Vol. I, p. 75, ln 20- p. 78, ln*; 19; *Lulka, Id. at p. 200, ln 8-13; and Id. at p. 232, ln 8-12; and Height, Id. at p. 60, ln 10-16),* one contemporaneously with Phillip's visit to Hillcrest, (*Lulka, Id. at p. 200, ln 8-13)* and one on the same day of his visit or the day before his visit. *Vol. II, p. 738 ln 22- p. 739, 1-3.* They all plainly observed his appearance and described it ranging from "not looking well", *(Vol. I, p. 62, ln 8-10),* to "greenish" *(Vol. I, p. 206, ln 1-2),* "ashen, grayish" color, *(Vol. I, p. 61, ln 10-12),* "not normal", *(Vol. I, p. 61, ln 5),* "real clammy looking" (Vol. I, p. 76, ln 19-20), to "like a zombie, like walking dead". *Vol. II, p. 738,* 22-24; p. *739, ln 1-3.*

4. None of these dramatic symptoms or notations are in the HMC medical chart. *Vol. IV, #89.* EMTALA violations are triggered by symptoms triggering the operation of a policy. If a patient presents with "A", then do "B". If a hospital is of the aptitude of dishonesty to avoid the financial expense, in attempting to avoid liability, it masks an EMTALA violation by purposely minimizing symptoms in the medical chart to make it appear as though no medical emergency existed. The patient would then be sent home on painkillers or a prescription and referred for follow-up at another hospital as happened in this case.[12] This is the theory advanced by Appellants based on policies not followed which are triggered by Phillips' ill-appearance.

5. According to HMC policy, *Vol. IV, Exhibit #47, p. 008 "D",* if a patient appears ill, the patient must go to the

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[12] Pursuant to HMC's motion in limine, the trial court did not allow testimony by those told by Phillips that HMC "wouldn't look at him because he had no insurance". Vol. III, #2, p. 157, ln 14-24.

emergency side, where more extensive testing is done. *Vol. I, p. 359, ln 24-25; Vol. II, p. 544, ln 12-13.* Phillips was triaged to the minor care side. *Vol. I, p. 238, ln 11.*

6. Just one hour prior to Phillips' visit to HMC, he had "gargulatious" sounds on his lungs which reminded Michael Dacewitz of his mother when she had walking **pneumonia**. *Vol. I, p. 88, ln 25, p. 82, ln 1-7.*

7. Just 4.5 days later, Phillips was taken to Tulsa Regional Medical Center, ("TRMC"), by his father. There the resident intern observed and noted Phillips' lungs were **fluid filled**, and was working him up for atypical **pneumonia**. *Vol. I, p. 111, ln 11-13.* This fact, linked with Mr. Dacewitz's testimony dramatically contradicts Dr. Cobb's dictation that Phillips had clear lungs. *See dictation, Attachment "M", or Vol. IV #89.* Fluid was present before and after Phillips' visit to HMC. Defendants intentionally minimized this symptom in the medical chart and made subsequent lies to cover it up. *See 9 and 10, below.*

8. Dr. Cobb's dictation says that Phillips is a well-developed, well-nourished, pleasant gentleman, and his examination was unremarkable. *Vol. IV, #89 (see dictation), or Attachment "M".* She explains, "I walked into the room, Phillips was sitting on the exam table. He was sitting there very quietly. He certainly **did not** – my words would be **appear to be in any distress**." *Vol. I p. 286 ln 2-5.* Dr. Cobb forgets this statement moments later, and testifies, "Phillips was not feeling well. I mean that was **obvious to** both **me** and him, and so for that reason I gave him several days off work." *Vol. p. 298, ln 14-16.* Dr. Cobb establishes evidence of her own mendacity. She admits Phillips appeared ill. *Vol. I, p. 238, ln 11.*

9. Dr. Cobb says in her dictation Phillips' neck is "stiff" and hurts even to *try* to turn it, yet she says *full* range of motion is noted. *Vol. IV, #89 (see dictation), or Attachment "M".* This

is not credible, and is evidence of document tampering, or concocting records, and Dr. Cobb is now tripping over those concoctions.

10. Appellants' Exhibit 45 is a triage sheet where symptoms have been **erased** and "**whited-out**". *Vol. IV, #45, See Attachment "P".* This tends to prove HMC covered its actions of changing and minimizing symptoms of Phillips' true clinical presentation to its emergency room.

11. Hillcrest thought Phillips had no insurance. *Vol. I, p. 333, ln 14.* Certainly, if Phillips had insurance, HMC would ask him back for any needed follow-up, but it chose not to, and for any follow-up, Phillips was referred to the free clinic. *See Emergency Dept. Treatment Record,(says "FU OU FP", means Follow up OU Family Practice), Exhibit #89, or Attachment "O".*

12. At HMC, patients without insurance, are STRONGLY ENCOURAGED to seek clinic referral. *Vol. IV, Exhibit 47, p. 6, or Attachment "N".* This tends to prove HMC is money conscious and intentionally did not treat Phillips commensurate with his presentation to HMC by purposely categorizing him as a non-emergency. Phillips was referred to the OU Family Clinic for those without insurance or financial ability to pay. *Vol. II, p. 993, ln 13-25; p. 994, ln 6-10.*

13. HMC admitted a question ("?") mark written under the disposition of Phillips means no diagnosis was made of Phillips to put there. *Vol. I, p. 337, ln 8-14.* This makes it more likely no attempt was made to "determine" whether Phillips had an emergency medical condition and shows he was not stabilized. *See question mark Vol. IV, Exhibit #28, or See Attachment "K".*

14. A person with chest pains and a fast heart beat was sent to the **emergency side**. *Vol. IV, Exhibit #25, or See Attachment "L".* HMC admitted Phillips had chest pain and a "fast heart beat" called tachycardia. *Vol. I, p. 264, ln 18; Id. at p. 259, ln 25- p. 260, ln 2.* Phillips was sent to the minor care side. *Vol. I, p. 238, ln 11.* Appellants submit, this is more circumstantial evidence of HMC's intentional mistreatment of Phillips because he was treated differently.

15. The risk management department of HMC was notified of Phillips' death **within** one week of Phillips' death, of September 28, 1998. *Vol. II, p. 682, ln 20, p. 689, ln 12-25.* The admission policy, in effect since July 24, 1995, was changed on September 30, 1998, two days after Phillips' death at HMC's sister hospital. *See Attachment "R".* Prior to September 30, 1998, **nurses** performed the medical examination. *Id.* After Phillips died, it now reads, "Under no circumstances is any patient to be refused treatment or referred to another facility without 'a medical screening exam by an **E.D. physician**'". This attests to why **nothing** is written in the "Emergency Dept. Treatment Record" (*See Attachment "O"*) as to: "physician's report"; "physical exam"; "time" patient was seen; "initial impression"; and why no new vital signs other than from the triage nurse, appear in the chart, because no exam was done by Dr. Cobb. She only authorized the prescriptions.

B. This Court Violated Separation of Powers

In an attempt to re-define or clarify its holding in *Repp v. Anadarko* Mun. Hosp., *43 F.3d 519 (10th Cir. 1994),* this court misconstrued the application of § 1395dd(a) of the Emergency Medical Treatment and Active Labor Act, ("EMTALA"), thereby foreclosing the original intent of 42 U.S.C. § 1395dd and thusly, this court violated the separation of powers of the United States Constitution. In addressing Appellants' EMTALA claim, this court held:

> To the extent it was unclear before, this court holds, as it implicitly did in *Repp,* a hospital's obligation under EMTALA is measured by whether it treats every patient **perceived** to have the same medical condition in the same manner. *(Emphasis added), See Phillips at p. 3.*

This holding violated separation of powers, and did so by legislating, overwriting and treading on what this court readily admits is the original intent of *42 U. S. C. § 1395dd*—to protect patients from hospitals which intentionally refuse care of a patient because of inability to pay for medical services. See *Phillips v. Hillcrest Medical Center, 2001 WL 200187, ---F.3d---, (10th Cir.(Okla.)),* (stating at p. 2, "Congress enacted EMTALA in 1986 to address the problem of "dumping" patients in need of **medical care but without health insurance**." **Also stating, "...originally intended to cure the evil ..." *Id.* emphasis added).**

Separation of powers is epitomized in the "very structure" of the Constitution in enumerating and separating the powers of the three branches of Government in Articles I, II, and III. *INS v. Chadha, 462 U.S. 919, 946, 103 S.Ct. 2764 (1983).* The Constitution prohibits one branch of government from encroaching on the central prerogatives of another. *See Loving v. United States, 517 U. S. 748, 757 116 S.Ct. 1737 (1996).* James Madison asserted the idea that "where the whole power of one department is exercised by the same hands which possess the whole power of another department, the fundamental principles of a free Constitution are subverted." *U. S. v. Smith, 686 F. Supp. 847, 853 (*quoting *The Federalist, No. 47, pp. 302-303 (C. Rossiter Ed. 1961)).* U. S. C. Const. Article I § 1 states, "All legislative Powers herein granted shall be vested in a Congress of the United States, which shall consist of a Senate and House of Representatives." This court encroached upon the prerogative of the Legislature.

This court's present interpretation of the § 1395dd(a), sets up the situation where medical personnel are rewarded to lie because if they purposely testify they did not "perceive" a patient's true presentation to their emergency room, when they in fact did, any EMTALA claim is defeated without even considering the truth that policies triggered by a patient's true presentation, were intentionally violated and not followed. In the case at bar, to permit medical personnel to merely testify that they "did not perceive that Phillips appeared ill" and take it as true, when by all accounts of independent witnesses, (four in this case), Phillips plainly appeared acutely ill, or as testified to by a trained emergency medical technician independent of HMC, Phillips looked like the "walking dead", totally ignores this court's admitted intent of the statute.

This court's holding, precludes the original intent of 42 U.S.C. § 1395dd from ever being realized except in those instances where hospital personnel admit their wrong-doing or admit that they did not follow established policies or procedures and it thereby negates the long held tenant that a witness by taking the stand puts their credibility at issue and is subject to cross-examination. (*See United States v. Havens, 446 U.S. 620, 626-27, 100 S.Ct. 1912, (1980)*, ("It is essential, therefore, to the proper functioning of the adversary system that when a defendant takes the stand, the [plaintiff] be permitted proper and effective cross-examination in an attempt to elicit the truth.") (*See also U.S. v. Tomlin, 46 F.3d 1369, 1390 (5th Cir 1995)* (taking the stand places a witness's credibility at issue). The reason this court's "perception" standard precludes the original intent of §1395dd, is according to this court, now, hospital personnels' versions of facts as to the medical condition of a patient are automatically taken as true and not subject to controversion.[13] This means lies cannot be challenged and

[13] Four independent witnesses undeniably controverted HMC's version that Phillips' did not physically appear ill, and with other evidence, created a question of fact as to whether the HMC triage category policy

intentional conduct is protected, thusly treading ever so severely, on the original intent of 42 U. S. C. § 1395dd.

The rationale of this court appears to be because "motive" or "intentional conduct" is not an element of an EMTALA violation. See *Phillips at 4.* "(This circuit... does not require any particular motive for EMTALA liability to attach. See Repp 43 f.3d at 522 n. 5 (stating EMTALA imposes strict liability)". "(EMTALA looks only at the participating hospital's actions, not motives. See Stevison, 920 F.2d at 713 ("We construe[section 1395dd(a)] as imposing a strict liability standard...)". Certainly the fact that Congress broadened the scope of 42 U. S. C. § 1395dd from its **original intent** to also encompass non-intentional failures to treat patients uniformly (i.e. "strict liability"), does not exclude the original purpose for the legislation from being realized. *See Phillips at 2.* (Congress's original purpose of EMTALA is to " cure the evil"). The applicable rule for this court to follow is "where Congress has made its intent clear, 'we must give effect to that intent.'" *Miller v. French 530 U. S. 327, 336, 120 S.Ct. 2246, 2253 (2000), (quoting Sinclair Refining Co. v. Atkinson, 370 U. S. 195, 215, 82 S. Ct. 1328 (1962)).* This court cannot construe 42 U.S.C. § 1395dd, so as to create a safe-harbor for intentional conduct, as does this court's "perceived" standard. To do so violates separation of powers.

This court **admits** the **original intent** of EMTALA, is to obviate or cure "evil". *Phillips at 2.* Certainly, in ferreting out and curing "evil", one is not dealing with that sort, which if gone unchecked, will abide in the aptitude of fairness. Relegating the entire outcome of a plaintiff's legitimate EMTALA claim to the likes of a subjective statement by medical personnel such as " I did not perceive this patient's severely hindered medical appearance or condition", is

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was violated intentionally. *See triage policy Vol. IV, Exhibit 47, p. 008 and p. 0016.*

tantamount to condoning the very evil this statute sought to prevent, and vests a hospital with total power, (absent its honesty), to never suffer the penalty of an EMTALA violation. "Power takes as ingratitude the writhing of its victims". *Rabindranath Tagore, Straybirds (1916).* How may "evil" be cured if it may do and say what it wills, knowing the power once given by Congress to keep it honest, is taken away by the Judiciary? The court must always allow intentional decisions by hospitals to refuse a patient treatment to be actionable under the EMTALA statute.

The question must always be are there facts supporting a plaintiff's intentional claim?

III. THIS COURT OVERLOOKED AN ENTIRE ARGUMENT ABOUT THE DRUG EVIDENCE ISSUE PRESENTED FOR APPEAL AND MISCONTRUED THE APPELLANTS' DRUG ARGUMENTS TO VIOLATE OKLAHOMA LAW

A. Argument Overlooked

This court overlooked Appellants' entire argument that drug evidence had no foundation based on *United States v. Farmer, 137 F.3d 1265, 1270 (10th Cir. 1998). See Appellants' Opening Brief, p. 26.* This court did not address the unfairness and fundamental lack of foundation of an "answer" to a fundamentally ambiguous question, being the fulcrum of a cause of action, (i.e., HMC's defense of contributory negligence), where there is nothing in the record establishing what the ambiguous question meant to the person answering the question. In this case, Phillips was deceased and there was no way of apprehending what the question, "Do you use drugs not prescribed by a physician?", meant to him. The trial court permitted HMC to put on testimony that Phillips had done drugs in his past, but no evidence was presented that Phillips used drugs anywhere close in time to the present tense question, "Do you use drugs other than those

prescribed by a physician?" *See highlighted portion of questionnaire, Attachment "Q".* This one document created HMC's argument for contributory negligence, alleging Phillips gave an incorrect HISTORY. This question does not go to Phillips' history, but is present tense, and cannot be the fulcrum of contributory negligence.

B. There Is No Causation Testimony For Contributory Negligence[14]

Under Oklahoma law, according to this court's own cited authority, *Graham v. Keuchel, 847 P.2d 342, (Okla. 1993),(See Phillips at 6, citing Graham),* contributory negligence, requires the alleged negligence on part of Phillips to be a contributing cause to his death, and that there must be evidence of contributory negligence before any such instruction may be given or it is reversible error. *Mouser v. Talley, 375 P.2d 968, 970, (Okla. 1962), Smith v. Chicago, Rock Island and Pacific Railroad 498 P.2d 402,404, (Okla. 1972)*("[C]ontributory negligence... is not a defense until there is some evidence of contributory negligence;"*), See also Graham at 354, & fn.53.* This court cited *Graham* to support the idea that failure to

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[14] Appellants' proposition that the trial court committed reversible error allowing drug evidence into this case involves Appellants' negligence action. HMC was negligent for failing to admit Phillips into the hospital and for negligent triage. HMC argued Phillips failed to reveal a drug history needed to diagnose bacterial endocarditis, and this caused his death. Appellants did not sue HMC, or Dr. Cobb, for failing to diagnose bacterial endocarditis, but for failure to recognize his acutely ill appearance and failure to admit him into the hospital. There was no nexus between what Appellants sued for and HMC's defense of negligence, hence the defense itself was misplaced and irrelevant. Dr. Zola testified bacterial endocarditis did not need to be diagnosed. *Vol. II, p. 512, ln 9-12; p. 506, ln 18-25; p.507, 1-3.* This court found Appellants' supplied this court no authority, and the distinction was unclear to this court. *See Phillips at 6, & fn 10.* Authority was supplied, "*Fed. R. Evid. 402", Appellants' Opening Brief, p. 19.*

provide medical history can provide the basis for a contributory negligence defense. *See Phillips at 6.* Yet, before one can get to that step, there must first be evidence of contributory negligence causing Phillips' death. *Id.* This is one of the points made with Appellants' argument in *Farmer. Id. at 1270.* There can be no evidence of contribution on part of Phillips withholding his medical history if the question, drafted by HMC, is fundamentally ambiguous[15], and there is no evidence establishing what it meant to Phillips. *See Id. at 1270.* Such a question should not be the fulcrum of a cause of action or defense. *Id.* Additionally, in light of no evidence or testimony showing Phillips "presently" used drugs when he "allegedly" answered the questionnaire, there can be no evidence he contributed to his own death. Drug testimony was past use only. *Vol. II, ln 14.* This doesn't establish a question of fact whether he withheld information causing his death.

Oklahoma requires Phillips to fall below the "reasonable care standard" in exercising his own acts. *Graham 354, & fn.53.* There was no testimony his actions in "allegedly" filling out the questionnaire were unreasonable, but to the contrary, Dr. Phillip Murta testified he expects drug users to deny drug use and Dr. Cobb adopted[16] that same position at trial. *Vol. I, p. 116, ln 24, - p. 117, ln 5.* Assuming at the relevant time, Phillips used drugs, it cannot be unreasonable for Phillips to deny drug use if evidence shows it is **"common"** for drug users

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[15] The question is certainly a "present tense" question. HMC argues it is a "past history" question.

[16] Q: Did you hear Dr. Murta...? A: Again... people are commonly embarrassed or do not want to admit certain habits such as drinking and drug usage. So whether or not you pursue that question and ask it repeatedly or delve into it, again would depend on the evaluation of the patient. In this case in evaluating Mr. Phillips, **I did not find** on his examination something **critical** that I felt I needed to go back and pursue that or delve past that, but certainly people can be very reluctant to admit their drug usage. *Vol. I, p. 311 ln 14 – p. 312 ln 3.*

to tend to deny it. The record is devoid of any evidence establishing Phillips acted unreasonably. Finally, **Dr. Cobb** testified Phillips' drug history was **not** "critical" to her evaluation of Phillips and chose **not** to "delve" into whether Phillips was truthful in his alleged response to the questionnaire. Since this is true, it cannot bear on Phillips' alleged contribution to his own death, if he was untruthful on a question Dr. Cobb deemed **not** "critical" to her evaluation. *See fn 12.*

Upon her evaluation of Phillips, Dr. Cobb deliberately and medically determined that she in fact did not need to have information on drug use. *Id.* This was her decision. *Id.* If she didn't need it, then to allege Phillips caused his own death as a result of not giving her information she didn't need, is absurd. The element of causation of contributory negligence is sorely lacking. Additionally, the record is completely devoid of any testimony establishing that Phillips' alleged failure to be truthful on the questionnaire contributed to his death. *See testimony of medical experts, Dr. Murta, Dr. Cobb, Dr. Bernauer, Dr. Sacra, Dr. Zola.* NO ONE testified Phillips failure to divulge this drug history contributed to his death. Under Oklahoma law, it was reversible error to allow this defense to be presented to the jury.[17] *Mouser at 970.* The trial court committed reversible error.[18]

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[17] Appellants objected and renewed their objection to this defense and instruction being given, just prior to the jury charge. *Vol. II, p. 1056, ln 20-24.*

[18] Appellants did not sue Defendants' for failure to diagnose bacterial endocarditis, yet their defense was Dr. Cobb needed this drug information to diagnose this disease because it is a cause for the disease. Once in play, fairness demanded the Appellants be allowed to rebut this contributory negligence evidence and proffered testimony by Dr. Zola to rebut the assertion by HMC that Phillips contributed (caused) his own death by failing to information that he was a drug "user", because drugs cause bacterial endocarditis. If Dr. Cobb needed drug information to diagnose the disease because drug use causes bacterial endocarditis then Appellants needed to rebut this argument with medical evidence showing

IV. CONCLUSION

WHEREFORE, because the trial court did not consider all the evidence, nor all policies presented on appeal, because this appellate court never considered "de novo", even, the policies the trial court admitted were violated,[19] because the trial court admitted in the light favorable to Appellants regarding Mr. Lulka's testimony that Phillips looked very ill, [20] because the trial court did not consider Appellants' intentional EMTALA violation, because this court never determined whether the "facts only pointed one way", because this court misapplied 42 U.S.C. § 1395dd(a) to create a "safe-harbor" for intentional conduct, violating separation of powers, encroaching the long-standing rule that a witness, by taking the stand puts his credibility at issue, and because it was reversible error to permit the contributory negligence defense when there was no evidence for it, this case must be reheard, reversed or re-briefed for truth and justice to continue to be recognized in these United States.

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drugs did not cause the bacterial endocarditis, and therefore he did not cause his own death. This court found that there was nothing in evidence to rebut, (i.e., no evidence that drugs were the cause of Phillips' bacterial endocarditis). *See Phillips at 7.* This court admitted, in Appellants' view, that there is no evidence of contributory negligence. *Id.* Either there was and Appellants were entitled to rebut it, or there wasn't and HMC was not entitled to a contributory negligence instruction. *See Mouser at 970, (reversible error).*

[19] In regard to HMC policy regarding patient reassessment and vital signs, *Vol. IV, Exhibit 97, "EPP0099, para. 7, and "EPP0154 #8,* Mr. Copeland: "They did not re-test his vitals, Your Honor." The Court: "I understand that." *Vol. p. 850, ln 11,12.* It is the rationale of HMC to recheck vitals because they may fluctuate and the patient may need to have tests on the emergency side. *Vol., I, p. 394, 9-16*; p. 391, 20-25; p. 392, 1-3; p. 394, 4-7; p.396, 2-12.

[20] *Vol. II, p. 903 ln 5-6.*

Respectfully submitted,
The Law Office of Gregory V. Copeland, P.C
On behalf of all Appellants
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ATTORNEY FOR APPELLANTS

Certificate of Mailing and Dispatch
To the Clerk of the Tenth Circuit

I, Gregory V. Copeland, certify that on April 25, 2001, and pursuant to **Fed. R. App. P. Rule 25**, I caused and dispatched an exact copy of the foregoing document by the U.S. Mail with the proper postage thereon to the Appellee's attorney, and by carrier overnight to the Clerk of the Court as set out below:

John R. Paul, Esq.
Christy Butler, Esq.
THE PAUL LAW FIRM
Nine East Fourth Street, Ste. 400
Tulsa, OK 74103-5118

Clerk of the Court
United States Court of Appeals
Bryon United States Courthouse
1823 Stout Street
Denver, Colorado 80257

/s/Gregory V. Copeland
Gregory V. Copeland

The following Attachments have been either omitted or relocated in this Appendix or Supplemental Appendix as noted:

ATTACHMENT "J" Affidavit of Gregory V Copeland. . . . . App 160

ATTACHMENT "K" Emergency Room Disposition of Phillips with no Diagnosis, only a (?). . . . . Supp. App. 25

ATTACHMENT "L" Emergency Room Log and Minor Care Log. . . . . Supp. App. 26 - 40

ATTACHMENT "M" Dr. Cobb's Dictation that contradicts itself as well as the emergency dept record . . . Supp. App. 12-13

ATTACHMENT "N" Hillcrest's Emergency Dept. Triage Policy page 6 . . . . . Supp. App. 26

ATTACHMENT "O" Phillips' Emergency Dept Record which consists of mostly blank spaces . . . . . Supp. App. 6-7

ATTACHMENT "P" Liquid White-out triage sheet, likely Phillips'. . . . . Supp. App. 24-25

ATTACHMENT "Q" Questionnaire..... Supp. App. 10-11

ATTACHMENT "R" Hillcrest's Emergency Dept. Admission Record changed two days after Phillips' death..... Supp. App. 28 - 31

ATTACHMENT "S" Hillcrest's Policies in part, that were not followed at Phillips' presentation to Hillcrest on September 23rd, 1998..... Supp. App. 32 -34

ATTACHMENT "T" Rule 50 Hearing..... App 21

(Attachment "J")

Northern District)
) ss.
State Of Oklahoma)

CRYSTAL STAR PHILLIPS, individually, and As next of kin to Martin Shane, on behalf of THE ESTATE OF MARTIN SHANE PHILLIPS By and through her mother, legal guardian and Next friend, MINNIE CHRISTINA DACZEWITZ, and FRED MARTIN PHILLIPS JR., parent of Martin Shane Phillips the Plaintiffs,

v.

HILLCREST MEDICAL CENTER, an Oklahoma corporation doing business in the State of Oklahoma, and CAROLYN COBB, a physician, and TULSA EMERGENCY PHYSICIANS, INC., an Oklahoma Corporation doing business in the State Of Oklahoma

the Defendants.

AFFIDAVIT OF GREGORY V. COPELAND

I, Gregory V. Copeland, the affiant, being of sound mind, legal age do hereby attest subject to penalty of perjury that I have personal knowledge of the following statements and the following statements are true and accurate to the best of my knowledge and belief:

1. That I was the attorney for Appellants at the trial of the matter styled:

2. That I have read the Tenth Circuit's opinion filed

in the appeal to this matter on March 26, 2001.

3. That this court specifically states at P. 4 of its opinion:

> The district court repeatedly implored appellants' counsel to describe the evidence showing that HMC failed to screen and evaluate Phillips' condition. In the interest of brevity, it is sufficient to say appellants' counsel reluctantly conceded HMC, either through Nurse Cue and/or Dr. Cobb, did in fact make a determination as to Phillips' condition with respect to each and every allegation of failure to abide by existing policy requirements. See Vol. II, p 829, ln. 19-20; Id. at p. 830, ln. 11 - p. 831, ln. 4; Id. at p. 831, ln. 5 - p. 832, ln. 4; Id. at p. 843, ln. 11 - p. 844, ln. 12.

3. That this attorney has read the cites associated to this court's concluded "conce[ssion]" on part of Appellants as "to each and every allegation of failure to abide by existing policy requirements", as set out in paragraph 3, above.

4. That this attorney has personal knowledge of the cites addressed in this affidavit in that myself and Richard S. Toon, were co-counsel for the Appellants at trial and that I was present when all facts herein were argued and that myself and co-counsel were arguing in concert as it relates to the theory of Appellants' case-in-chief and the following addressed citations by this court are clear to my personal knowledge and belief as well as logic interpretation from the context, that this

court misconstrued the statements made in response to the trial court's questions as to the following:

5. For instance, in regard to *Appellants' Vol. IV, Exhibit 47, p. 008 "D"*, this court cites *p. 829, ln 19-20*. In this exchange with the trial court, this court appears to have concluded Appellants conceded that HMC Medical Center ("HMC"), either through Dr. Carolyn Cobb or Nurse Lugenia Cue, legitimately undertook to make a determination of whether Mr. Phillips appeared acutely ill. The following exchange between the trial court and counsel for Appellants took place:

> The Court: There's a difference between an EMTALA question and a negligence question.
> Mr. Toon: I agree.
> The Court: Stay with me on the EMTALA question.
> Mr. Toon: Okay.
> The Court: Did she undertake to make a determination of whether he appeared acutely ill?
> Mr. Toon: It seems like she did, yes, sir, from what I recall.

6. That counsel for Appellants' statement, "It seems like she did, yes, sir, from what I recall", is addressing the fact that this is the argument put forth by the HMC's employees or staff and <u>not</u> that this is what Appellants concede the evidence shows.

7. That if this court will look at the context of this exchange this court will see from the previous page that counsel for Appellants is making that

exact point, (i.e., "Of course the people from HMC indicated that he didn't appear that way..."). *See p. 829 ln 10-18 which reads*:

> The Court: And the testimony, the sole testimony was he did not appear acutely ill; right?
> Mr. Toon: Well, that's not entirely accurate. I think that's a factual issue, Your Honor, because Mr. Lulka in his testimony said that he had the sweats and he had the chills, so that's an issue about whether he did or not. Of course the people from HMC indicated that he didn't appear that way, but Mr. Lulka testified, I believe, that was the he looked like. It sounds like he was acutely ill.

In fact, the trial court admitted there is a question of fact as to Phillips looking very ill as it relates to Michael Lulka's testimony. *Vol. II, 903, ln 5-7.* (The Court: "Well, the fact that he thought he looked very ill and was sweating was not in the helpful category, at least for purposes of your motion right now.").

8. This same type of contextual misinterpretation occurred where this court makes its next citation regarding *p. 830, ln 11- p. 831 ln 4*:

> (Beginning at line 9, p. 830)
> The Court: Did she undertake to make a determination as to whether or not that was a significantly abnormal vital sign?
> Mr. Toon: I don't know if she undertook that or not, sir. I know that --
> The Court: She testified to it.
> Mr. Toon: Well, she noted - -

> The Court: She said she didn't believe it. She noted it and didn't believe that it was significantly abnormal; right?
> Mr. Toon: Well, she testified, I believe that it was not, but at the time she didn't say whether she undertook at that time whether it was or not, from what I recall.
> The Court: Well - -
> Mr. Toon: And if she misses it that doesn't mean that she gets out.

9. The question being addressed in this court's reference beginning on p. *830 ln 11 – p. 831 ln 4, is regarding Appellants' Vol. IV Exhibit 47, p. 008 "I"*, is whether or not Appellants thought the testimony by Nurse Lugenia Cue reveals she undertook to determine if Mr. Phillips' vital signs were abnormal. Appellants' counsel clearly says at lines 19-20 of p. 830, that she didn't say whether she undertook to determine such, but that Nurse Cue, testified she did not believe Mr. Phillips' vital signs were abnormal, and at line 23, consistent with Appellants' belief that HMC was not being upfront and honest about Mr. Phillips' presentation, Appellants' counsel stated, "And if she misses it that doesn't mean she gets out."
Then, on *p. 831, ln 4*, the trial court cuts off Appellants counsel's explanation again. Never did Appellants' counsel concede that Nurse Cue legitimately "undertook" to determine whether Mr. Phillips' vital signs were normal or abnormal.

10. This court next cites *p. 831, ln 5- p. 832, ln 4*, which is in regard to *Appellants' Vol. IV, Exhibit 47 p. 008, "O"*. The following exchange took place:

> Mr. Toon: There is "O", regarding a person under 30 years old that presents with pleuritic type chest pain and is

diaphoretic.

The Court: Right. Did she undertake to determine whether or not he was diaphoretic?

Mr. Toon: I don't - - I think her testimony was that he was not. But that is a fact question - -

The Court: Right. So she undertook to determine it. She might have been wrong; right? But she undertook to determine it, and we also know that because that's on the chart; isn't it? No sweats, no shortness of breath, no nausea. Right?

Mr. Toon: That's Dr. Cobb. That's not the triage.

The Court: In the triage didn't she say on the stand that she undertook to determine whether or not he was sweating.

Mr. Toon: She said that she recalled that he was not sweating.

The Court: Right.

Mr. Toon: Right. But then she - -

The Court: Okay. She might have been wrong. That's a fact issue as to whether or not she was wrong in that determination, but if she undertakes to make that determination, if she gets it wrong then, then that's cognizable under state malpractice law, but it is not cognizable under EMTALA.

Mr. Toon: I disagree, Your Honor.

11. In this exchange, <u>never did Appellants' counsel concede</u> that Dr. Cobb, Nurse Cue, or anyone on behalf of HMC <u>legitimately undertook</u> to determine whether Mr. Phillips was "diaphoretic" or that Mr. Phillips had other symptoms triggering *Appellants' Vol. IV, Exhibit 47 p. 008, "O"*. In fact, Appellants' counsel never conceded any point

other than to admit what personnel for presented as to their version of what they did, and never did Appellants' counsel concede any of the Defendants' versions were the truth, but instead, when presented with the trial court's argument, Appellants' counsel stated, "I disagree", standing on the legal premise that this court cited twice in its opinion in this case entered on March 26, 2001:

> See Repp, 43 F.3d at 522 n.5 (stating EMTALA imposes strict liability). EMTALA looks only at the participating hospital's actions, not motives. See Stevison, 920 F.2d at 713 ("We construe [section 1395dd(a)] as imposing a strict liability standard subject to those defenses available in the act.")
>
> *See Phillips v. HMC Medical Center, 2001 WL 290187, 4 (10th Cir. (Okla.)).*

and therefore, HMC's failure to follow its established policies lends itself to "strict liability" and if the policy was not followed, HMC was strictly liable for non-deminimus policy deviations, or at the very least it was evidence that Mr. Phillips was treated differently than other patients in his similar circumstance, or as further argued by Appellants, it was evidence of HMC's intentional decision not to legitimately determine whether Mr. Phillips had an emergency medical condition, in light of the fact that four witnesses: Barbara Height, James Cooper, a trained emergency medical technician, Michael Lulka, and Michael Dacezwitz all independent witnesses, testified to Mr. Phillips very ill appearance. These policy deviations are not the sole evidence of the EMTALA violation.

12. Then finally this court cites *Vol. II p. 843, ln 11 – p. 844, ln 12* which is a passage of nothing short of myself continually rebutting any statement the trial court is making and there is absolutely no concession there. Perhaps this court made a superfluous cite.

13. Clearly, in writing the opinion of this court entered on March 26, 2001, this court erroneously concluded that Appellants had conceded HMC ("HMC") in fact made a determination as to Mr. Phillips' condition with respect to "each and every allegation of failure to abide by existing policy requirements".

/s/Gregory V. Copeland
Gregory V. Copeland

Subscribed and affirmed before me under penalty of perjury this 24 day of April 2001.

/s/Terri Strizek
Notary Public

My Commission expires:

2/15/03

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

CRYSTAL STAR PHILLIPS, individually, And As next of kin to Martin Shane Phillips, on behalf of THE ESTATE OF MARTIN SHANE PHILLIPS, By and through her mother, legal guardian and Next friend, MINNIE CHRISTINA DACZEWITZ and FRED MARTIN PHILLIPS JR., parent of Martin Shane Phillips	)	**FILED MAR 31 2000**
the Plaintiffs,	)	**Case No. 98-CV-829H(E)**
vs.	)	
HILLCREST MEDICAL CENTER, an Oklahoma corporation doing business in the State of Oklahoma, and CAROLYN COBB, a physician, and TULSA EMERGENCY PHYSICIANS, INC., an Oklahoma Corporation doing business in the State Of Oklahoma	)	
the Defendants.	)	

REPORTERS TRANSCRIPT OF PROCEEDINGS

HAD ON DECEMBER 13, 1999
THROUGH
DECEMBER 17, 1999

JURY TRIAL - VOLUME I-V

BEFORE THE HONORABLE SVEN ERIK HOLMES, Judge

bacterial endocarditis, which is not really the evidence at all. So I have --

THE COURT: The ruling is and it continues to be and it has been for ten pretrials that nobody is going to testify about the cause of death. That's the limitation. Right?

MR. HOLEMAN: That was part of it, Your Honor, and I think part of the other --

THE COURT: The cause of the bacterial endocarditis.

MR. HOLEMAN: Yes, Your Honor.

THE COURT: Bacterial endocarditis is the cause of death, but nobody is testifying that they know, because they don't know, what caused the bacterial endocarditis. But the fact of universe of what potential causes are is, and continues to be, and has been for ten pretrials open for discussion. All right. What else have you got, sir?

MR. TOON: Actually Dr. Zola does know what the cause is within a reasonable degree of medical certainty, but our understanding is that we are not going to get into that by the Court's order.

THE COURT: Right. He can talk about other causes of bacterial endocarditis. All right. Go ahead.

MR. TOON: Then, sir, regarding Dr. Cobb's deposition testimony which looks like it's Page 3. We never really -- we had talked about it and under Rule 32 that a party's deposition can be used for any purpose. I understand the Court's ruling

the evidence will show, that Dr. Cobb thought of bacterial endocarditis when she examined Mr. Phillips. The evidence is going to be that when a doctor thinks of that life threatening disease there are certain things that you are required to do under good standard medical care. Number one, a blood test. It's a simple test. Number two, a chestX- ray. That's a simple test. Number three, an EKG. That's a simple test. Those three simple tests were not only not done at Hillcrest, they were never even ordered at Hillcrest.

You are going to see that Dr. Cobb prescribed Mr. Phillips Norflex. Ladies and gentlemen, Norflex is a muscle relaxer. Norflex doesn't treat infections in the blood, Norflex does not treat infections involving the heart.

Additionally the evidence is going to show in regards to Norflex it is common knowledge in the medical community that you are cautioned about prescribing that drug to patients with heart beats over a hundred. Martin Phillips' heartbeat was well over a hundred. He was tachycardic. That drug never should have been prescribed to him.

Now, two days later after Dr. Cobb sees Martin Phillips she decides that she is going to dictate her emergency room note, and when she dictates her emergency room note two days later, does she call Martin Phillips and let him know I prescribed you the wrong drug. Come back in. The evidence will show she never did. Dr. Cobb did not provide one

antibiotic to Mr. Phillips, not one to treat his infection. The evidence will be that Martin Phillips should have been admitted into the hospital. He should have been admitted under Hillcrest's own policies and procedures. That's another policy and procedure they violated. And these policies and procedures, ladies and gentlemen, are the ones that they created, that they drafted and that are in their own emergency room. The same thing that Dr. Carolyn Cobb thought of when Martin Phillips was at the ER on September 23rd is the same thing that contributed to his death less than five days later. The evidence will be, if he had been treated on September 23 of 1998 he would have lived. He would have lived.

You're going to see that Hillcrest thought that Martin Phillips did not have insurance. You're going to see that he was not treated appropriately because he didn't have proof of insurance that day. We are going to prove to you, the evidence is going to show, that Hillcrest discriminates against people that don't have proof of insurance in the emergency room.

You're going to hear about a federal law. This federal law requires hospitals like Hillcrest to provide an appropriate medical screening to some patients. Marty Phillips was one of those patients. Marty Phillips was never provided an appropriate medical screening at Hillcrest. You are going to hear that Hillcrest, even before Marty Phillips saw Dr. Cobb, had already decided to release him from the emergency

person named Martin Phillips?

A. I do not know -- I do not know the time of year.

Q. Okay. You recall sometime in September of 1998 you saw Mr. Phillips?

A. I -- no, I can't specifically say when. I remember the recall of an incident.

Q. Okay. You recall an incident?

A. Right. Of a gentleman.

Q. Okay. And what do you recall about an incident, ma'am?

A. That there was a gentleman that came into our office. I am the receptionist and everything else up front. And he -- someone was with him and he came in and asked to be seen. I did not have a doctor in my office -- I don't know why specifically I didn't at that time -- and stated I did not have a doctor and told him he would have to go to an emergency room or something within his insurance benefits.

Q. Okay. And do you remember that person now being Martin Phillips?

A. That's what I have been told.

Q. Okay. You have no reason to disagree with that, do you?

A. No. Except I don't know who Mr. Phillips is.

Q. Okay. And when this individual came in, can you describe the color of the person's face?

A. I said I did not think he looked well.

Q. Well, you have been more specific than that in the past.

A. Right.
Q. So let me ask my question a little differently if I wasn't clear. Did the person's color look normal or not normal to you?
A. I said I didn't think he looked normal.
Q. You described the color of his face in your deposition that you took; is that right?
A. Yeah, but I'm not so positive. Colors are vague and I'm not so sure. I just didn't think he looked well.
Q. Did you previously describe him as being more ashen looking, okay, more grayish?
A. Yeah, I said that.
Q. Ma'am, is East Side Family Practice, or you said Briarwood, I believe?
A. Yes. We are now.
Q. Is that connected with -- I'm sorry?
A. We are now.
Q. Is that connected with Hillcrest?
A. I am now as of January 1
Q. Now, do you recall having a conversation with me about anything to do with a person describing chest pains to you?
A. I believe you called me.
Q. That was before your deposition; right?
A. Yes.
Q. And at that time did you indicate whether the person asked

how did that go about?

A. Two years on nights and three years on days. So an accumulation of five years

Q. And what kind of employee was he?

A. He was dependable, rarely missed work. A real smart individual.

Q. Did you have a friendship with Mr. Phillips?

A. Yes, I did.

Q. Now, it's been admitted by all parties in this case that Mr. Phillips died on September 28, 1998. Do you remember that day?

A. Monday.

Q. Okay. And how do you recall that it was on a Monday that he died, just for the jury's benefit?

A. Well, Martin had missed work all prior to that Monday, all that week before and it was -- I'd seen Martin mainly throughout that week he had missed. And Sunday I didn't see him and I was curious, out of curiosity when Monday morning rolled around if he would be at work, and when he wasn't.

Q. So do you specifically recall the day of his death, were you present when he died?

A. No, I was in transport to the hospital.

Q. I'm sorry?

A. I was in transport to the hospital where he was when he died

A. He looked like he had definitely had a flu, you know, he was using a heating pad for -- he was laying on a heating pad and was complaining of aches and pains and thought the heating pad may aid in his pain.

Q. Okay. So on Tuesday he had cold symptoms, flu symptoms, aches and he was a little bit -- he was worse, doubled, and he was not at work; is that right?

A. Yes.

Q. Okay. I hope -- I can't read my own handwriting, I hope the jury can. Not working. Okay. How long were you there on Tuesday; do you recall?

A. 10 or 15 minutes.

Q. And did you just go on home at that time?

A. Yes.

Q. Then I guess you came back to work or what happened on Wednesday?

A.Wednesday morning when we hadn't heard from Martin right off, I believe it was his landlord or his landlady that had called in for him that morning and said that --

MR. BEGIN: Objection, Judge. That calls for hearsay

THE COURT: Overruled. Go ahead.

A. And said that someone needed to go and check on Martin, which on that time Jim Cooper, which was my boss, come in and relayed the message. At noon Wednesday, me, myself and Mike Lulka went at lunch and checked on Martin.

there wasn't an immediate response and then Mike knocked again and hollered at him and Martin responded. And just to the nature of our friendship and stuff we just walked on in.

Q. Okay.

A. And basically let ourselves in. Which he was laying in his bed. By Wednesday he was laying on multiple heating pads, really not feeling good, he was in a lot of pain. Real raspy sounding to his voice.

Q. Okay. Let me back you up a second. On Tuesday I remember you said he was on a heating pad7 is that right?

A.Yes.

Q. Okay. You said it was on Wednesday that he was on more heating pads?

A. He had three or four heating pads.

Q. So basically what were his symptoms at that time or what did you see, observe him? Did you learn that he wanted to get up and answer the door or is that just something that occurs?

A. He didn't want to. He just basically didn't want to get out of bed. He wasn't feeling good. You know, he was real clammy looking, his voice was real raspy and he complained of lot of pain.

Q. So on Wednesday you said he was clammy. And can you describe how is it you know he was in pain?

A. Oh, it was obvious. I mean just the way a person talks when they are in pain.

Q. What do you mean by that?
A. The way they are stuttering like they are holding in pain. Trying to -- so you wouldn't notice how they are --
Q. So he was somewhat stuttering?
A. Yes.
Q. Okay. Did he basically have all of the same symptoms on Wednesday but I guess the addition of clammy, pain and stuttery or as he did on other two days?
A. Yes, but the pain, the pain he was enduring Wednesday was like of no pain he had had in the week, the two days before. He was in tremendous pain.
Q. Did you -- when you were there on Tuesday, did you ever mention to him you ought to go to the doctor?
A. On which day, sir?
Q. Do you recall if on Tuesday that you—all talked about he should go to a doctor?
A. Yes, I told him he ought to go to the doctor, but then again Martin wasn't one that really ever got sick and Martin wasn't one to ever really want to go to the doctor.
Q. Okay. So what happened on Wednesday. Did you and Mike Daczewitz leave by yourself or what happened?
A. Me and Mike Lulka.
Q. I'm sorry.
A. We left, went over there. And in his condition then he didn't have a choice. Mike Lulka told him that he was going to

MR. COPELAND: Thank you.

Q. (By Mr. Copeland) What time did you-all get back to the shop?

A. We were there 10 or 15 minutes at Martin's place and it takes two or three minutes to track there and then track back. So I'd say we were back by 12:20, 12:25.

Q. Okay. And did Mike Lulka, to your knowledge, then head off to take him to a medical care place?

A. He took him to Dr. Wheeler which is our company physician and some of them use him as a private physician too.

Q. You weren't with Mike Lulka when that occurred though; correct?

A. No.

Q. Well, I'm not asking you to testify to what you later learned from someone else so.

A. Okay.

Q. Did you see him any other day that week other than Monday, Tuesday and Wednesday?

A. Yes.

Q. Okay. When else did you see him?

A.I saw him Thursday evening -- or Thursday morning.

Q. Thursday morning. And what was the occasion that caused that visit or your encounter with him?

A. I was in the shop working and I seen him -- I seen him come in and go into the break room and I walked up to him to

Cooper, that he had handed his doctor documents to just to show, you know, vouch for his time missed.

Q. Okay. So on Thursday did he have basically all of the same symptoms and did he actually even look a little worse on Thursday?

A. He was sweaty.

Q. Sweaty.

A. The pain, it's hard to interpret. The pain that he was -- he was, he had a lot of inner pain and --

Q. Did you notice -- I'm sorry.

A.-- and he was just real raspy in his voice. I kind of related it to a walking pneumonia or a relation like that.

Q. Why would you relate it to that?

A. Well, I've never seen anybody with full—blown pneumonia, but my mother had walking pneumonia a few years back and I thought that that may have been what was wrong with Martin.

Q. Okay. And did you notice if he had any congestion in his lungs, is that --

A. The raspiness, that's what I -- to be honest with you, it sounded like he was somewhat gargulatious (phonetically), you know what I'm -- not a congestion but like a fluid on his lungs is what I mean by raspiness.

Q. Okay. Fluid on the lungs?

A. Type of a sound.

Q. When was the first time you noticed that type of a sound?

Was it on Thursday?

A. No, he sounded -- he sounded like he was getting raspy, I believe like Tuesday or Wednesday, but every day that went by it multiplied, I mean it got worse.

Q. Do you know to your best recollection whether that sound was on Tuesday or Wednesday?

A. Tuesday, I believe.

Q. Okay. Did you ever notice him sweating other than Thursday?

A. Yes, Martin was "he was clammy Wednesday. He was sweating. Tuesday he just had a clammy look to him, I guess like a damp look.

Q. And Wednesday did you say he also looked like he was sweating? How did you say that, how did you phrase that?

A. He had a clammy look but he had the beads of, you know, the sweat accumulation. He wasn't sweating but he had sweat beaded up on his forehead.

Q. Was that on Wednesday?

A. Yes.

Q. So we have covered Monday, Tuesday, Wednesday and Thursday. Is that all you recall on Thursday about how he looked and how he was acting?

A. Yes.

Q. Okay. Did you see him leave the office or the break room?

A. He left, he went through -- I went back out into the shop

someone that lived by Martin, a couple of houses down and -- or a couple of blocks. And throughout that week as I was leaving work I was trying to get ahold of this guy on buying this motorcycle and that's when I would swing by Martin's place. Saturday as I was driving to his house I saw Martin driving his car from I'm not sure where he was coining from, but I passed him on the road and I stopped him going through the addition where he lived.

Q. And how would you describe him when you saw him in his car?

A. To tell -- to tell you the truth he was almost -- It was bad. He was like all but alive. He was crying, sweating profusely and kind of hunched over the steering wheel, clutching his chest.

Q. Okay. Did you meet him on the road?

A. Yes.

Q. Did you notice anything unusual whenever he was coming toward you?

A. He just didn't drive like Martin. I mean he was just kind of putting around real slow and like I said, I'm not certain on where he was coming from. I know he was headed back home.

Q. So you saw him on Saturday on the road. When he was crying, when you say he was crying was he crying out loud or how was he doing?

A. He was extremely crying.

A. I was the resident on duty. I worked with an attending on that shift.

Q. You are still a resident; correct?

A. Thankful, yes.

Q. Well, you're almost done.

A. Almost done. Right.

Q. Well, sir, on that day were you responsible in part for the care of Martin Phillips?

A. Yes.

Q. When Martin Phillips came to the Tulsa Regional Medical Center Emergency Room that morning, how did he look physically to you?

A. My first impression was that he was somebody that was about ready to die.

Q. And that would have been about 5:30 in the morning you thought that?

A. When he presented.

Q. Can you describe the color of his face when you saw him?

A. The color of his face was -- he was sallow in appearance, very pale, dark.

Q. Ashen?

A. That's a fair description.

Q. Doctor you ordered some specific tests that morning, didn't you?

A. Yes.

Q. What was the name of that antibiotic, doctor?

A. The antibiotic is called Rocephin. It's very powerful, it's one of the strongest antibiotics that we have. Sometimes we liken it to using a shotgun to kill an ant. It's a very powerful weapon.

Q. Did you give him a single dose or a double dose?

A. Actually we gave him double the dose.

Q. Doctor, did you also order a chest X-ray?

A. Yes.

Q. Do you know what that showed?

A. It showed that he had fluid building up in his lungs, his heart was slightly enlarged. My initial impression was that he had an atypical pneumonia. Pneumonia was in our working diagnosis. The attending physician and I somewhat disagreed. She thought it was more of a heart failure picture. I thought it was heart failure and infection.

Q. Heart attack?

A. Well, not necessarily heart attack. More buildup of fluid in the lungs because of a poor pumping mechanism in the heart from whatever reason.

Q. Did Mr. Phillips relay to you anything about being at a different health care facility within the prior week to seeing you?

A. Yes.

Q. And did he tell you the hospital?

A. I think he did. Yeah, he definitely said Hillcrest. I did not dictate it as Hillcrest. I said it in my dictation it's another hospital in town.

Q. Yes, sir.

A. Okay.

Q. At that time when you did your dictation you also indicated, did you not, that he had similar symptoms at the previous hospital?

A. Yeah. That was one of the areas we were having trouble trying to figure out what was going on with him. We refer to people as being good historians or bad historians. He was clearly a bad historian. There was some difficulty in determining exactly what had happened because he indicated to me that he had been sent home with the diagnosis of neck strain and sent home on appropriate medicines for that. I used the word "similar symptoms" in dictation. And I don't recall, quite frankly, what the specifics of our conversation was regarding the symptoms but I know it was difficult to qet a history from him. Some people will tell you, they explain what's going on. Other people you have to ask very specific questions, do you have this, do you have that, do you have this, and he was more along that end of the spectrum.

Q. You're saying again as far as him not being a good historian, that was because of his physical condition?

A. More than likely, yeah.

Q. I mean, you didn't feel he was trying to hide something from you, did you?

A. I didn't think he was trying to hide anything.

Q. When you saw Mr. Phillips was he having any type of respiratory difficulty or going like, huh, huh, huh (panting), anything like that?

A. He was breathing fast and he had mild to moderate respiratory distress. It was manifested by some movements on his chest wall that would indicate he was working a little harder to breath. His oxygen level in his blood as registered on our monitor was low/normal. It was right at the range where you as a doctor you start to get concerned about it but it's not something that needs to be corrected right then.

Q. Now, doctor, when you took the history from Mr. Phillips in the morning, I take it at the hospital you asked him about drugs or drug use; didn't you?

A. Yes, I did.

Q. And did Mr. Phillips indicate to you whether he uses drugs?

A. He denied using drugs.

Q. And even though he denied it, you went ahead and did those tests that we talked about; is that right?

A. The?

Q. The complete count.

A. Yes.

to die.

MR. TOON: That's right. But it does counter. It counter's their --

THE COURT: Objection is -- it doesn't counter it at all. The objection is sustained. All right. Let's go to work.

(Whereupon counsel returned to their respective places and the following proceedings were had within the presence and hearing of the jury.)

THE COURT: All right. Mr. Toon.

MR. TOON: Yes, sir.

THE COURT: Please proceed, sir.

MR. TOON: One moment please, Your Honor.

THE COURT: Yes. Go ahead.

MR. TOON: I believe I'm just about finished.

THE COURT: All right.

Q. (By Mr. Toon) Doctor, were there any tests that you performed after Mr. Phillips told you that he did not use street drugs?

MR. HOLEMAN: Object as repetitious.

THE COURT: Overruled. Go ahead.

A. Everything that we ordered, we ordered more or less up front as a battery of tests so that didn't influence my decision to order tests.

MR. TOON: Thank you, sir. Thank you, Your Honor.

proof of insurance?

A. No.

Q. They don't at all?

A. Absolutely not.

Q. Do you treat people differently at Hillcrest when they don't have proof of insurance?

A. No.

Q. Do you have any written policies out there that indicate that you discriminate against individuals that don't have proof of insurance in the emergency room?

A. No.

Q. Ma'am, if I could, up to your right there is a -- maybe I can approach, Your Honor, and help?

THE COURT: Yes. Go right ahead.

Are you going to different exhibit, sir?

MR. TOON: Yes, sir.

THE COURT: What exhibit would that be?

MR. TOON: That would be No. 47, Your Honor.

THE COURT: All right.

MR. TOON: May I take this from you?

Q. (By Mr. Toon) If you could, Ms. Delsorbo, will you please turn to Exhibit No. 47.

A. Okay.

Q. You would agree with me this is a triage manual?

A. Yes.

Q. Do you require --do you require your triage nurses to follow this policy?.

A. Not this particular one anymore. This is an old one.

Q. Okay. Well, and I appreciate you letting us know that. How about on September 23 of 1998?

A. Yes.

Q. So on September 23 of 1998, when Martin Phillips was at the emergency room, the triage nurse was required to follow that policy?

A. Yes.

Q. And you have already told us that you don't discriminate against individuals regarding insurance; right?

A. Yes.

Q. Okay. Turn with me to page 6 of that policy.

A. Okay.

Q. Ma'am, I have highlighted something under triage Category III; do you see that?

A. Yes.

Q. Would you please read the highlighted sentence to the jury?

A. "These patients will be strongly encouraged to accept clinic referral unless they have proof of insurance coverage.

Q. So at Hillcrest Medical Center you-all have a policy that if you put somebody as a triage Category III, and they don't have proof of insurance, you or the triage nurse is going to

policies but this was not being done.

Q. Okay. So am I to understand correctly that you have a triage manual that you say was in effect on September 23 of 1998, and some of it was supposed to be followed by employees and some of it wasn't?

A. Yes. And going back to that, I think that over the last two years at Hillcrest, I think the last four years, no one had been asked to do this. These policies just were not updated. No one ever asked to pay $60.00 dollar co payment or asked for like proof of insurance in order to be seen by a physician.

Q. So, ma'am, I asked you earlier if this triage manual was in effect. Is your answer really no?

A. No, it really is in effect. I'm just that this portion of the policy was not being followed.

Q. Okay. And you also --

A. And I did agree with that. I did agree with that patients shouldn't be asked that and shouldn't be based on their ability to pay.

Q. I agree. When you went to Hillcrest, when you started your job, did you see this policy and have a problem with it?

A. Well, there were several things. I was going through my first 60 days, there were several, several issues that I was looking at and I don't know that anybody possibly could have seen thousands and thousands of pages of policies and correct them within 60 days.

Q. Well, ma'am, let me ask you this. There's only one triage manual; isn't there?

A. Correct.

Q. Okay. And this triage manual is how many pages?

A. I haven't counted.

Q. It's in right in front of you and I think it's pretty -- it's pretty short.

A. Do you want me to count?

Q. Well, I think they're numbered.

A. Okay. It's 29 pages.

Q. So the triage manual is not thousands and thousands of pages you -- all have thousands and thousands of pages of other policies and procedures?

A. I didn't say that. I said there are thousands of pages in my department that I'm responsible for, not just a triage protocol manual. And this is a protocol manual to go by.

Q. Yes. And in September of 1998 did you expect your triage nurses to be aware of what was in this manual?

A. I certainly think that they all were aware of this, yes.

Q. And was this particular manual physically in the emergency room?

A. Yes.

Q. Ma'am, if I could have you turn to the next page, Page 7. And for a triage -- out of all fairness on the previous page it started with Triage category IV, and it talks at the top that

A. Yes, sir.

Q. Okay. And you had an occasion to go see Martin Shane Phillips on that day and take him to the hospital; is that right?

A. Yes, sir.

Q. And how did that come about?

A. I believe that the daughter of his landlady came by work and said that he was sick and someone needed to take him to the doctor. And so I was -- I kind of finished up my job, it was right before lunch, and I finished up what I was doing, so me and another guy from work went over to see him because he just lived a half mile away. And when we went over there it looked like he was real sick, so I said I would take him to the doctor.

Q. Okay. Who was it that you went over there with?

A. Mike Daczewitz.

Q. Okay. And whenever you got to Mr. Phillips home how did he appear?

A. He was laying on his bed just really hurting, felt real bad. To me his color was real bad. You know, he was just feeling miserable and said he wanted to go to the doctor, so we said we would take him right then.

Q. Okay. And how did that take place? Did you'll have to help him into the car or was he on his on or --

A. We helped him kind of into the car, you know, he could

walk a little bit but he was -- said he was really hurting and everything.

Q. Did you notice if he had any weakness about his body?

A. Yes, he was real weak.

Q. What -- generally speaking, what kind of a stature of a person is he?

A. He's usually very healthy, you know.

Q. Did you labor -- do any manual labor with him?

A. Yes, that's what we do.

Q. Was he a strong gentleman?

A. For his size he was extremely strong I would say.

Q. Okay. And what time is it that you went over to see Mr. Phillips?

A. I would say we probably got there about 12:05.

Q. Okay. And then how long were you present at his place?

A. Long enough to get him up to go. Five minutes at the most.

Q. Did you go -- where did you go after that?

A. We went back to work and I let Mike off and had him go in and tell the boss that I would be taking Martin to the doctor.

Q. Okay. And then what did you do?

A. We went to Dr. Wheeler's clinic, is the doctor and when we got there they told us to go ahead and take him to the hospital, and then we took him to Hillcrest.

Q. And Dr. Wheeler's clinic, is that the same thing as East

Side Family Practice?

A. I believe so.

Q. Okay. And when you got to East Side Family Practice, did Martin go inside?

A. Yes, he walked in with me.

Q. Okay. What happened, what transacted at that point, exactly?

A. We walked up to the nurse's window thing and we told them, I don't know if it was me or Martin, one of us said that he's having chest pains, and without doing anything they told us light then to go ahead and take him to the hospital

Q. Okay. I-low long were you there?

A. Probably two minutes at the most.

Q. Okay. And while you were there did Martin clutch his chest or lean over on anything?

A. He kind of just sat in the chair, I believe, while I talked to the nurse.

Q. Okay. Why were you talking and not Martin, do you know?

A. He just -- he felt so badly, you know.

Q. And then you proceeded to go where?

A. To Hillcrest.

Q. Okay. What time did you arrive at Hillcrest?

A. I would guess it might be between 12:45 and 1:00 that afternoon.

Q. And what was the first thing that you recall doing when

Q. (By Mr. Copeland) What was Martin's symptoms while you-all were sitting there waiting?

A. Well, he was -- it kind of changed as we were sitting there. Sometimes he would seem like he was cold.

Q. I'm sorry?

A. Sometimes it seemed like he said was cold and then he would be sweating. And most of the time he was, you know, he was holding his chest kind of.

Q. Was he ever laying down in the emergency room?

A. He kind of huddled over in a chair a little bit, didn't lay completely down, but just kind of slumped over.

Q. Okay. Was he -- did he cry at all while he was present the emergency room?

A. I don't know if he cried at the emergency room, but he cried some, a couple of times during the time I picked him up and at that time, you know, he had tears in his eyes and stuff from the pain.

MR. COPELAND: Just a moment, Your Honor.

Q. (By Mr. Copeland) Do you remember giving your deposition back on May 19th of this year?

A. Yes, sir.

Q. Do you remember this question being asked on line – Page 35, line 14.

"Question: Okay. Now when you got to the hospital now you were sitting there in the reception area, describe

crying at the hospital and so I was showing that he was crying at the hospital.

THE COURT: Well, why don't you find out exactly what he is saying first about the tears in his eyes. It's not clear to me that he's ever said he was crying.

MR. COPELAND: Okay. That's semantical.

THE COURT: Tears in the eyes.

MR. COPELAND: I understand.

THE COURT: So we're not going to be leading him with his deposition testimony. All right.

MR. COPELAND: Okay.

THE COURT: All right. Let's go to work.

(Whereupon counsel returned to their respective places and the following proceedings were had within the presence and hearing of the jury.)

THE COURT: All right. Mr. Copeland, sir, please proceed.

Q. (By Mr. Copeland) Now, would you agree or disagree that Martin had tears in his eyes in the emergency room?

A. I would agree.

Q. Okay. Would you -- do you know whether or not he still had, you said when you saw him back at his house you thought his color didn't good?

A. Yes, sir.

Q. Can you describe the color, what color, do you recall it?

A. To me I thought he looked kind of greenish, you know. That's what I would describe it as.

Q. Okay. Was he sweating while he was there at the emergency room?

A. Part of the time he was.

Q. Did his appearance of his hair look like it was matted and--

A. Yes, it did.

Q. Okay. And you said he was cold. Did you take that to mean he was having the chills?

A. That's what I took it to mean, I believe.

Q. Was he, in your opinion, was he in pain while he was in the emergency room?

A. Yes, he was.

Q. Do you recall if he was shaking while he was in the emergency room?

A. At times he was.

Q. Now, how long were you there from the time that you arrived at Hillcrest Medical Center until the time that Martin Phillips was seen by somebody?

A. By a doctor or by a--

Q. By a medical personnel that was actually administering some kind of medical treatment rather than a registered person, someone in registration?

A. I would guess an hour and a half, two hours, something

A. Yes.

Q. And did he sometimes not have cigarettes with him, he needed to borrow one?

A. In the past he had, you know.

Q. Okay. It didn't bother you?

A. No.

Q. All right. Now, when we arrive at the emergency room I believe you have testified that you eventually went up to a window where you gave a lady some information?

A. Yes.

Q. Okay. And you were with him?

A. Yes.

Q. And you showed her your insurance card?

A. Uh-huh.

Q. Right?

A. Yes.

Q. Okay. And that took maybe five or ten minutes?

A. Approximately.

Q. And that process seemed to be fairly routine; didn't it?

A. Yes, it did.

Q. They were just getting biographical information?

A. Right.

Q. And the fact he had his insurance card or didn't have his insurance card wasn't a particular big deal, was it to them?

A. It was kind of -- but it wasn't that big a deal, you

Daczewitz said it could have been 10 to 15 minutes, your recollection is not even five minutes. it could have five minutes still; right?

MR. PAUL: Objection, Your Honor. Argumentative.

THE COURT: If we can just ask him what he remembers, sir.

MR. COPELAND: Okay.

Q. (By Mr. Copeland) So you say five minutes?

A. I say five minutes.

Q. So that would put it at 12:08 you left Martin's. Would that be pretty close?

A. That would be pretty close.

Q. Okay. So you dropped off --

A. Mike at our shop and I didn't even get out of the car. He went in and told them where I was going.

Q. So if you left Martin's at 12:08, it takes two or three minutes to get back to the shop?

A. Right.

Q. So to be fair we will say it's 12:11 at that point at the shop?

A. Right.

Q. Would that be right?

A. That would be correct.

Q. Now how long does it take to stop and get a soda pop that you bought for Martin? One or two minutes?

Family Practice and you left at 12:40, you would get at Hillcrest Medical Center at 1:00; is that right?

A. That's right.

Q. Do you dispute any of those time frames?

A. I'm sure they are all within five minutes I would say.

Q. So to be fair we will add another five minutes on here and you got there at 1:05 and presented to the emergency room; is that right?

A. I'm sure that's pretty close.

MR. COPELAND: Thank you. That's all I have, Your Honor.

THE COURT: All right. Mr. Paul.

RECROSS-EXAMINATION

BY MR. PAUL:

Q. Mr. Lulka, would you just agree with me that the times can be a little hazy?

A. I agree with that.

Q. All right. When you stopped at this convenience store?

A. Yes.

Q. Was it a QuikTrip?

A. Yes, it was.

Q. One there about 46th and North Lewis?

A. That's correct.

Q. Did Martin go in with you?

A. No, he just asked me to get him something.

Q. Okay. What did you get him?

A. I believe a Pepsi.

Q. Okay. And did he drink that before he got to East Side Family Practice Clinic?

A. He drank part of it and he left it in the car and then actually it was still sitting in my car at the end of the day.

Q. I see.

A. He didn't ever finish it.

Q. He didn't finish it?

A No.

MR. PAUL: That's all.

THE COURT: All right. Mr. Begin.

MR. BEGIN: No further questions.

THE COURT: All right. The witness may step down -- why don't you just remain seated.

Ladies and gentlemen, we will take a break at this time. I remind you not to discuss this case with anyone or with each other. Please do not independently investigate any aspect of the case and form no conclusions until all of the evidence has been fully presented.

If everyone in the courtroom will please remain seated and the bailiff will take the jury out. We will take about a ten minute break.

(The following proceedings were had outside the presence and hearing of the jury.)

where they were; is that a fair statement?

A. I didn't know where in the department at that moment they were kept. They are moved.

Q Does Hillcrest require you to be familiar with the policies and procedures of the emergency department?

A. No, I would not say that's a requirement.

Q. Does Hillcrest require you to follow written policies and procedures in the emergency department?

A. No.

Q. When you're examining a patient after the patient has been through the triage process where they see the Hillcrest nurse, do you rely on the triage nurse in any way?

A. I rely on the judgment of the triage nurse to make the appropriate decision.

Q. Okay. The appropriate decision as to whether to send the patient to minor side or emergency side?

A. The appropriate decision as to whether the patient needs to be brought back immediately or whether it can be triaged and taken in sequence.

Q. Yes. And if a patient presents to the Hillcrest Emergency Room and they are acutely ill, the triage nurse is supposed to bypass the triage process and go directly back to the doctor; is that right?

A. If that clinical situation exists, yes.

Q. In the times that they don't appear acutely ill or the

Q.Yes. And the way that you know about whether there is an infection in the blood, septicemia, is to do what as a doctor?

A. Evaluate the patient.

Q. Yes. And in addition to evaluating the patient that would -- that includes various diagnostic tests; is that correct?

A. It would depend on the evaluation of the patient.

Q. Well, Doctor, can you tell us, is there a diagnostic test out there that you can order in the emergency room, that's simple to order, that can tell you whether there is an infection in the blood stream or not?

MR. HOLEMAN: Excuse me, Your Honor, it's argumentative. It's assuming that there is infection present. So he hasn't laid a foundation, and his question is vague and confusing. Object to the form.

THE COURT: Overruled. She can answer the question. Go ahead.

Q. (By Mr. Toon) Doctor? Would you repeat the question?

Q. Yes. Is there a simple diagnostic test that you can do to determine whether a person has infection in their blood or not?

A. It is possible to order blood cultures to see if there's infection in the blood.

Q. Yes. And blood cultures are the gold standard; aren't they?

A. Yes.

Q. And once you order those blood cultures, you receive back in the emergency room, what the person's white count is; correct?

A. No. You're confusing your tests.

Q. Okay. Now, I want to be clear, and so please help me. You receive -- I'm sorry, let me ask it this way. You receive the blood work back that will indicate to you whether there is an infection in the blood?

A. If we are speaking about blood cultures, blood cultures are drawn and placed into a media and they take several hours to grow. So you may receive a 12-hour report on their growth, it may be 24 hours, it may be 48 hours, it may be 72 hours. So on a blood culture you will receive back if and what grows in the bloodstream. So you may or may not have that information in the emergency department at the time you're seeing the patient.

Q. That then determines -- it depends on, excuse me, whether the patient has been admitted into the hospital or not also; correct?

A. It doesn't depend on their admission one way or the other. It depends on the time frame of when the blood culture was drawn.

Q. Yes, Doctor, and there are times when you actually order these blood cultures in the emergency department; right?

blood; is that correct or incorrect?

MR. HOLEMAN: Excuse me, Your Honor, I object unless counsel specifies at what point in time.

MR. TOON: When she was examining him.

THE COURT: If you could. Go ahead and --

MR. TOON: I'll rephrase it, Your Honor.

THE COURT: Rephrase. Thank you, sir.

Q. (By Mr. Toon) Ma'am, when you were examining Mr. Phillips on September 23 of 1998, did you think he might have an infection in his blood?

A. Any time I see a patient anything is a possibility. As I went through my evaluation of Mr. Phillips that did not seem indicated or appropriate.

Q. So did you consider it and rule it out?

A. The answer to that would be, yes. I considered it because it's always in the differential. As I evaluated Mr. Phillips it became less likely.

Q. And at that time when you examined him and you considered that he could have septicemia you knew that you could order blood work?

A. Mr. Toon, when I examined Mr. Phillips I could order anything that was indicated.

Q. Yes. And Hillcrest allows you to order diagnostic tests in the emergency room; don't they?

A. Hillcrest allows me to order diagnostic tests, of course.

Q. And a blood work or blood count, those are both simple tests; aren't they?

MR. HOLEMAN: Excuse me, Your Honor. This is inappropriate, asking if it's a simple test. Self-serving and not based on this patient.

MR. TOON: It is, Your Honor.

THE COURT: Overruled. He can ask that. Go ahead.

Q. (By Mr. Toon) Doctor, are those simple tests?

A. Those are simple tests. They can be easily ordered and done, yes.

Q. And EKGs can be easily ordered and done; correct?

A. An EKG be can be easily ordered and done.

Q. And a chest X-ray?

MR. HOLEMAN: Excuse me, Your Honor. We're now rehashing, we're not talking about this patient. Object, it's repetitious.

THE COURT: He can finish up on the EKG and then you will be moving back to this patient. Go ahead.

MR. TOON: I think I said -- the last one was chest X-ray, Your Honor. She answered on the EKG.

THE COURT: All right.

MR. TOON: And that's my last test.

THE COURT: Go ahead.

Q. (By Mr. Toon) correct?

correct?

A. I can order any test. I can order a chest X-ray.

Q. Now, on September 23 of 1998 when you examined Mr. Phillips did you consider whether or not he had bacterial endocarditis?

A. Bacterial endocarditis was certainly in the differential before I evaluated the patient.

Q. So what you're saying is that before he ever came back to see you, you had already thought he had could have bacterial endocarditis?

A. Bacterial endocarditis is in the differential diagnosis of any chest problems, any chest pain.

Q. So when you examined him the thought of bacterial endocarditis was in your mind at that time, prior to him being discharged?

A. When you walk in the room the list of possibilities that a patient can have is endless. Certainly it's one of the ones that is included in the differential that I thought of. It became less likely as I evaluated Mr. Phillips because he did not have a fever, a rub, or give a history that would indicate such a thing.

Q. On September 23 of 1998, Doctor, did you confirm that Martin Phillips did not have septicemia?

A. I guess that would mean -- you are using the word confirm. My clinical evaluation did not indicate that.

Q. And your clinical evaluation was just your physical exam

of him, looking him over?

A. The medical evaluation consists of several parts. The first part being the history. Physical examination is a part of the evaluation and also the circumstances surrounding your seeing the patient.

Q. On September 23 of 1998, did you confirm that he did not have bacterial endocarditis?

A. It depends on what you mean by the word confirm it, His evaluation did not indicate endocarditis.

Q. Doctor, on September 23 of 1998, you realized, didn't you, the importance of finding out whether a person has those two infective processes; correct?

A. What two infective processes are you talking about?

Q. Well, I'm talking about two infections, bacterial endocarditis and septicemia; is that right?

A. All right. Now, you are talking about bacterial endocarditis and septicemia. Now, what is your question?

Q. You knew on September 23 of 1998, it was important for you to find out whether or not a person had either of those two infections; correct?

A. If a patient's evaluation indicates the need for that it is certainly important to find that.

Q. And as a doctor in the emergency room at Hillcrest Medical Center, you have an obligation to the patient to provide them with the proper medical workup; right? I mean, that makes

Q. And after examining Mr. Phillips, how long did you wait before you dictated your medical note for Mr. Phillips' chart?

A. I saw Mr. Phillips on the 23rd and we were very busy that day and I did not -- I could not go out and dictate afterwards, so I took home with me the two sheets that I needed, and I did not have a chance to dictate his chart until, I believe, two days later.

Q. So you took some of the records home with you from the hospital; right? You said two sheets?

A. When I don't have time to dictate a chart at the hospital I take the face sheet that would have their name and number and review of systems home with me or take or keep them with me in order to dictate it then at a time when I have -- when I can do it.

Q. Okay. Are those the only two items you took home to rely on in doing your dictation?

A. Yes. Those would be the only two.

Q. And after you did that, did you ever return them to Hillcrest?

A. No, I probably threw them away because Hillcrest -- I make copies and take them. I don't take the actual medical records out of the department.

Q. Ma'am, would you agree with me the closer in time you do your dictation the more accurate it's probably going to be?

A. No, that's not necessarily true because I had a good

what medications you prescribed to him?

A. Urn.

Q. And I should say all of the medications because you do list Parafon Forte there?

A. Well, the Parafon Forte was written on the emergency department record that I had at home with me.

Q. Okay.

A. The discharge summary instructions I wrote out myself. And I did not have a copy of the discharge instructions at the time I dictated the note. So that is the reason I said please refer back to the discharge sheet, because I knew that I had myself written names of the prescriptions on the discharge sheet, and rather than put erroneous information there I referred you to where I felt I knew -- I mean where I knew I had written the names myself.

Q. Well, the reason you wrote "I believe, It is because at the time you did your dictation you didn't know for sure, did you?

MR. HOLEMAN: Excuse me, Your Honor. Object as a repetitious. I also ask that counsel get back to the podium.

THE COURT: Well, what I would ask right now since we are on this, is just that you rephrase.

MR. TOON: Okay.

THE COURT: All right. And when you're done you will, of course, return to the podium but go ahead with this.

MR. TOON: Yes, sir.

A. Mr. Phillips had a pulse of 112 at the time he was triaged and first came to the emergency department. When I examined Mr. Phillips myself, which would have been sometime before he was discharged, I listened to his heart and I knew that his pulse rate then was less than a hundred. I listened to his heart. So I was not -- I was not concerned about tachycardia as a reason not to use the Norflex, no.

Q. Oh, so it actually went through your mind at that time as to whether the patient had tachycardia or not; right?

A. I knew that the vital sign of 112 had been recorded earlier. I also knew, however, that I listened to his heart. When you listen to his heart through a stethoscope, I listened to it, (knocking) and I've listened to enough hearts to know he was not tachycardic when I listened to him, and that would have been shortly before he was discharged. So it wasn't a problem.

Q. Well, Doctor, then if the nurse was right then in that he had tachycardia, because 112 is tachycardic; isn't it?

A. 112 is slightly above one hundred. It's tachycardia.

Q. And on 112 it wouldn't be (slow knocking), it would be (rapid knocking), wouldn't it?

A.Those vital signs there were the ones taken when he first came in at 1:00. That was not when I saw him.

Q. Where are your notes, Doctor, that you indicate what his heart rate was? Where is it on there?

A. It's not written down, Mr. Toon.

A. If the nurse filled that out they would usually put their initials on it that they had done so. Sometimes the nurses will do so if a person is having vision problems or if there's some other reason for them to, but it's usually signed and noted that someone else filled it out.

It usually is but sometimes it's not; correct?

A. Anything is possible.

Q. Okay. And sometimes you have found, Doctor, that the nurse doesn't always get down into the chart everything that has been told to her by the patient; right?

MR. HOLEMAN: Excuse me, Your Honor. Now we're getting far failed about this and it's irrelevant.

THE COURT: Sustained.

Q. (By Mr. Toon) Doctor, do you know on September 23 of 1998 whether all of the symptoms that were relayed to the triage nurse made its way into the triage note?

A. No, because I wasn't there. I don't know what all Mr. Phillips said to Jeannie.

Q. Did you prescribe any antibiotics to Mr. Phillips?

A. No, I did not.

Q. When you prescribed him the Norflex -- scratch that. Ma'am, your final diagnosis for Mr. Phillips was what on September 23 of '98?

A. My final impression was paracervical myalgia which means soreness and tenderness in his neck. And I also put pleuritic

type chest pain which would indicate pleurisy, musculoskeletal type chest pain.

Q. Did you ever tell Mr. Phillips what was causing his pain?

A. Mr. Phillips and I discussed it when I was in the room with him. I don't know the exact words. I can't 4 4 give you a verbatim of the conversation.

Q. Okay, I'm not asking for verbatim. I just want to know if you recall telling him what was causing his pain?

A. I know that we discussed that.

Q. Whose decision was it to discharge Mr. Phillips from the emergency room at Hillcrest?

A. It was my decision.

Q. Did the nurse play any role in that decision?

A. No.

MR. TOON: One moment please, Your Honor.

THE COURT: All right.

MR. TOON: May I approach please, Your Honor

THE COURT: Go right ahead.

MR. TOON: One moment please, Your Honor. For some reason I'm not finding it. Sorry, Your Honor, I've looked at this so much it's all run together.

Q. (By Mr. Toon) Doctor, on the day that you dictated this note you indicated that Mr. Phillips was a pleasant man; is that right?

A. Yes.

there's a whole complete picture, kind of like a shot that you get. And I walked in the room and Mr. Martin Phillips was sitting on the examining table. He was sifting there very quietly. He certainly did not -- my words would be he didn't appear to be in any distress. He was not moving restlessly around. He was not sweating. He made good eye contact with me. I always go in and introduce myself and I shake hands with the patient, and sat down on a stool beside him so that he could talk to me. And when you shake hands with someone, also it's an opportunity to look at their hand and you. Can feel if it's warm and make a contact. And you can also take their pulse. So I asked him then -- all the while you're looking at him and talking to him. I asked him to give me -- tell me why he was here, give him a chance to talk to me and tell me what he wanted to -- what was bothering him and based on that I asked him more direct questions that I needed to know from a medical stand point.

Q. Before we get into that, Doctor, what did Mr. Phillips indicate the problem was? Why was he there to see you?

A. He had come in that day because his neck was very sore. The back part of his neck, the big muscles in his neck, and it was sore to turn his head from side to side, he was very uncomfortable because of this persistent soreness, and also he had had some episodes of chest pain when he breathed in and out.

just list some of the things that before you evaluate a patient with chest pains, just list a few of the things that can cause chest pain?

A. It's a long list and it comes from many different causes. Chest pain, and I think the one most people think of first is a heart attack. It can come from the heart. You can also have pericarditis which is an inflammation around the heart. Pneumonia. An infection in the lungs can cause chest pain. You can have a pneumothorax which is a collapsed lung where there is air that has filled the pleural space between the lung and the chest wall that causes chest pain. You can have trauma to the chest as in car accidents. Actually someone just hitting your chest, being beaten up causes chest pain.

Q. It's a long list?

A. Yes.

Q. Okay. I don't want to make you go through everything. But I just wanted to ask you, Dr. Cobb, well, you know, if those were initial possibilities before the evaluation, why not just admit the patient and give him all of these tests that Mr. Toon asked you about?

A. Well, because that doesn't make sense.

Q. Why riot?

A. The evaluation -- because that's not good for the patient. That's just not how you treat people. You look at the patient and you evaluate what the problem is they are

having in order to know what to do about it.

Q. And so when you evaluated this patient on that date based upon what he told you and what you found, did his evaluation and finding indicate the need for any of these tests?

A. No, his evaluation did not indicate a need for any further testing.

Q. What did the evaluation indicate?

A. His evaluation indicated that we were down -- we, I'm saying he and I, were -- had gone through most of the life threatening possibilities and we were now down to the more benign possibilities for neck pain and chest pain which usually are musculoskeletal or viral or one of the things that you simply let time take its course.

Q. All right.

MR. HOLEMAN: May I?

THE COURT: Go ahead.

Q. (By Mr. Holeman) Dr. Cobb, is the history that you get from a patient, in other words what the patient tells you on forms or in words, is that significant to you as a clinician?

A. I'm sorry?

Q. Is the history that the patient gives you significant to you as a clinician, is it important?

A. Absolutely.

Q. How so?

A. Because the history, the history is essentially what --

for a doctor to know so knowing whether they smoke cigarettes, knowing whether they drink alcohol and knowing whether they use drugs are important risk factors for various medical problems. And particularly drug usage suggests a whole category of infectious processes and liver problems that the normal population is not at risk for. So it changes your differential in terms of what you would immediately think about. And drug use is a red flag for multiple other medical problems.

Q. And so if they answered yes to that question regarding the red flag, might that change how you need to proceed clinically?

A. It changes the evaluation, yes.

Q. What were your discharge instructions to Mr. Phillips, Dr. Cobb?

A. Mr. Phillips was not feeling well. I mean that was obvious both to me and to him, and so for that reason I gave him several days off of work for him to rest. I suggested that he might try heat or ice for comfort to his neck. There's many type of local measures that could make him more comfortable. I gave him prescriptions for the anti—inflammatory Naprosyn and for the muscle relaxer Norflex that he could use, hopefully, to make himself more comfortable. And I told him that if things did not get better to please come back either to our department or to see his own doctor.

Q. And Mr. Toon asked you about antibiotics. Why didn't you give the patient antibiotics?

A. The evaluation did not indicate any need for antibiotics.

Q. You have heard what his condition was five days later at TRMC--

A. Yes.

Q. -- during these proceedings?

A. Yes.

Q. Is that how he presented at Hillcrest five days before?

A. No.

Q. Would that have completely changed what you did or not?

A. Would what have?

Q. If he presented to Hillcrest as he had presented to T1RMC five days later, would you have ordered the same battery of tests that they did?

A. Absolutely. I mean his clinical picture was entirely different when he presented at Tulsa Regional.

Q. But on the date you evaluated him, Dr. Cobb, based upon what he told you and what you found, was there any way for you to foresee what was going to happen to him five days later?

A. No.

Q. And did you use your best clinical judgment and knowledge and expertise in order to reach the best diagnosis for this patient?

A. Yes.

Q. And did your care, Dr. Cobb, on the date in question, in any way fall below the standard of care?

DIRECT EXAMINATION

BY MR. COPELAMD:

Q. Please state your name for the record and spell your last name for the benefit of the court reporter, please?

A. LaDonna Stepp, S-T-E-P-P.

Q. Is it Miss Stepp or Mrs. Stepp?

A. Miss.

Q. Okay, Ms. Stepp. Ms. Stepp, where are you presently work?

A. Hillcrest.

Q. Hillcrest Medical Center?

A. Yes.

Q. The hospital down here on 11th and Utica approximately?

A. Yes.

Q. And how long have you worked there?

A. Two years.

Q. And in what capacity is your job operation there?

A. I do the registration.

Q. And what does that entail?

A. Just patient processing.

Q. What does that mean for the benefit of the jury, can you explain that?

A. We just do the paperwork.

Q. So when someone comes into the emergency room you are the person that gets the ball rolling, so to speak, as far as registration and their information?

MR. COPELAND: Okay.

(Whereupon counsel returned to their respective places and the following proceedings were had within the presence and hearing of the jury.)

THE COURT: All right.

MR. COPELAND: Can I finish the last two questions?

THE COURT: Go ahead, Mr. Copeland, please proceed.

Q. (By Mr. Copeland) Now, Ms. Stepp, on right at the very end of the page "disposition of case," the question mark that pertains to Martin Shane Phillips. What does the question mark mean based off your training and experience at Hillcrest Medical Center?

A. I'm sorry, it looks to me that they didn't have a diagnosis to put in there.

Q. Okay. And the charts with a check mark there, does that mean that you charge him?

A. No.

Q. Okay. Now, let me direct your attention to the admission to the department policy. Do you handle the information for admissions to the emergency department side also?

A. Yes.

Q. Okay. I direct you to the Plaintiffs' Exhibit No. 44 in that book that you are looking at I believe.

MR. COPELAND: Your Honor, may I approach?

THE COURT: Yes, go ahead.

A. The symptoms they present with, their past medical history, their age.

Q. Okay. Anything else?

A. Not that I can think of right off.

Q. Do you base it at all as to how long the patient is going to need to be treated?

A. Yes, by the length of stay.

Q. So before the patient sees the doctor you have already decided in your mind how long the patient is going to need to be there; is that fair to stay?

A. I have no idea how long a patient is going to be there but I look at the patient, what he's presenting with, the way he appears to me and then make that decision. If the situation changes when he is in the minor care area he would be immediately transferred to the ER side.

Q. Okay. So if you're trying to figure out how long a person is going to wait there, then how does that weigh into your decision making in where to send them?

A. I'm sorry. I don't understand the question.

Q. I believe before you said that one of the ways that you decide whether a person goes to one side of the emergency room versus the other is to how long you feel they are going to need to be there to get treated; right?

A. By the require -- if they would need extensive tests or different things, yes.

A. That's the time the triage nurse took the gentleman, Mr. Phillips' first vital.

1. Okay. And what do the numbers under that represent? I believe there are four. There are three numbers and then there's a blood pressure; right?

A. Yes, sir.

Q. Okay. Who did those numbers?

A. Who wrote those numbers?

Q. Yes.

A. I wrote those numbers.

Q. Okay. Did you redo his blood pressure on that day?

A. No, sir, I didn't.

Q. Okay. Did you redo his respirations that say 16?

A. No, sir.

Q. What about his pulse at 112?

A. No, sir.

Q. And I think it says 98 temp; did you take his temp?

A. No, sir.

Q. Okay. You just transferred basically what was on the triage sheet over?

A. Yes, sir, I did.

Q. Okay. Did you also, is that also how you transferred -- did you transfer over some of that paragraph that you read to us how it hurts in his neck for three weeks; is that something you also transferred over from the triage?

1 nurse is supposed to document the reassessment and it says will
2 occur there. Do you see where it says will occur?
3 A. Yes, sir.
4 Q. Okay. And the second page to that says what, "every two
5 hours or prior to discharge if length of stay shorter than two
6 hours;" do you see that?
7 A. Yes, sir, I do.
8 Q. Was that done in this case with Mr. Phillips?
9 A. No, sir, I did not recheck his vitals.
10 Q. One of the reasons that you want to check a person's
11 vitals, or recheck, is to make sure that their condition is not
12 fluctuating, right?
13 A. Correct.
14 Q. And that's important to know for not only you but for the
15 doctor that's going to examine the patient?
16 A. Correct.
17 Q. Now, when you saw Mr. Phillips had he completed any type
18 of questionnaire that you can recall. And I can show it to you
19 if you need me to?
20 A. The history form?
21 Q. Yes. I believe, is it the questionnaire history form?
22 Yes.
23 A. Yes, sir.
24 Q. You did see that?
25 A. I'm sure I did. I can't say honest for sure I did but

A. Yes, sir.

Q. Okay. And that's what should have been done; right? And I'm not trying to beat up on you I just want to, I'm setting up the question. Okay?

A. Okay.

Okay. That should have been done; right?

A. Yes.

Q. Okay. And if is done and you determine that the patient has now become a patient more suitable for the other side of the ER, the emergency side, you have the power to send them to the ER side; is that right?

A. Yes, sir.

Q. Now, when this emergency room or emergency department, if it says ED, does that mean emergency side or minor side?

A. ED means emergency department.

Q. The agency?

A. The whole -- yes, sir.

Q. Okay.

MR. TOON: May I approach, please, Your Honor.

THE COURT: Go ahead.

Q. (By Mr. Toon) Ma'am, can you just tell us briefly what this is?

A. This is a discharge paper for patients to sign before they leave the hospital.

Q. Okay. And down on the bottom left your signature looks

THE COURT: I believe the testimony has been limited to what she saw.

MR COPELAND: Okay.

THE COURT: All right. Go ahead.

Q. (By Mr. Copeland) Ma'am, do you -- how much time did you spend around Martin Phillips?

A. We saw him every holiday. Our kids played together. They came over for dinner.

Q. And what kind of individual was he in your opinion?

A. He was a good brother. He loved his family very much. His dad and him had a very close bond.

Q. Did you ever see him around his daughter Crystal?

A. Oh, yeah.

Q. And what kind of things in context did you see them do?

A. She was always on his shoulders.

Q. And did you see him like take her roller skating or any of those kinds of events, anything stands out in your mind that you saw the two do?

A. Yeah, we have gone to park together, he would push her on the swing, they would go for walks in the woods and pick up pine cones and things like that.

Q. Do you know, on his behalf, whether you were trying to get him in to see a doctor on that Sunday?

A. He called and asked me for help to see a doctor and I told him that either Don or myself would come pick him up and we

1 would figure something out.

2 And how long was he at your house on that Sunday?

3 A. Around 45 minutes

4 Q. And what was his behavior during that course of time? Was

5 he sitting down or what was he doing?

6 A. He walked into my garage, and I have a little table at my

7 kitchen window which is the first room in the house. He walked

8 in sat down and he didn't move again until he left.

9 Q. Did you notice if he had any congestion in his lungs?

10 A. He sounded weak he was having a hard time talking and

11 breathing.

12 Q. What do you mean by he was having a hard time talking.

13 Can you describe that with a little more specificity?

14 A. He seemed out of breath.

15 Q. Okay. Did he ever sound like he had a strain in his voice

16 or anything of that nature?

17 A. A little bit. I mean, he coughed quite a bit. He was a

18 little bit raspy.

19 Q. Do you know how it is that he called you on -- what day

20 did he call you?

21 A. Sunday.

22 Q. Okay. Did you have any contact with him on Saturday?

23 A. No.

24 Q. Is Sunday the only day that you saw him in regard in

25 relationship to his illness, the appearance that you are

describing here today?

A. When he was alive, yes.

Q. Did you ever know Martin to be a sick individual?

A. Never.

Q. Did he in fact want to go to the doctor?

A. Indeed. He was crying, asking for help.

MR. COPELAND: Nothing further.

THE COURT: All right. Mr. Begin.

CR0SS-EXAMINATION

BY MR. BEGIN:

Q. Just so the record is clear, you don't have any personal knowledge of what Martin Phillips looked like on September 23rd, 1998; correct?

A. What day was that?

Q. This was Wednesday, September 23rd?

A. No. No, sir.

Q. Okay. In fact prior to this Sunday that you just testified about, you had not seen Martin for approximately a month; is that correct?

A. Yes.

Q. Okay. You also had -- prior to this telephone conversation that you described on Sunday, you had not had any prior telephone conversations with him for approximately five days; is that correct?

A. Yes.

1. Center?

2 A. Well, I was checking on him during the evening that we all
3 went to bed and I would go up to check on him every now and
4 then, but about 3:00 o'clock in the morning I heard him. He
5 sounded like he was crying, so I went upstairs immediately and
6 I said come on let's go. And he was coughing up blood, too.
7 Q. Had you made a phone call to a Dr. Scott prior to that
8. Time?
9 A. Yes, I did. I tried calling him that Sunday and I tried
10 calling him Saturday, but he evidently was out of town or he
11. never answered.
12 Q. What did you leave a message with his answering service?
13.A. Yes.
14 Q. And to your knowledge had Christie attempted the same
15. thing?
16.A. I think she did.
17.Q. Whose doctor was Dr. Scott?
18.A. Christie's.
19.Q. Now, you just testified that when you went up and you
20 heard him crying, that you said let's go. That was at what
21. time?
22 A. It was after 3:00 o'clock in the morning. By the time he
23 got ready to go and we drove all the way down into downtown
24 Tulsa from over near Claremore we arrived over there.
25 Q. If the medical chart at Tulsa Regional Medical Center says

Q. Did he ever become somewhat confused or delusional, that you recall, in the context of not even being able to recall his own name?

A. I don't think he was that confused. He knew who he was. I know he was in a lot of pain and he was struggling for breath a lot.

Q. Now, there came a point in time -- now, before you were told, were you told by Dr. Stacy to call out at his employment to find out if he had a drug history?

A. The second doctor.

Q. The second doctor?

Yes.

Q. Now, before the second doctor came on, you were aware, were you not, that I think you have testified, that the X-ray and all of those things had been completed?

A. Yeah.

Q. And in your mind had you been told that there was -- basically they were not going to release him from the hospital at Tulsa Regional Medical Center at that point?

A. It wasn't in my mind. I knew they wasn't going to let him go.

Q. Now, did you make a phone call at the request of the doctor or did you make the phone call on your own?

A. Well, the doctor insinuated to me and give me the impression that he needed to know that information. Whether he

said go call, I don't think he did. I think he just wanted to know and asked me if I could find out.

Q. Fred, were you present when Marty, in this very sick condition, adamantly denied drug use?

A. Yes, I was present.

Q. Do you know your son to be a truthful individual?

A. I always thought he was.

Q. Do you think he would -- knowing what you know about him, do you think he would have told the truth when his life was on the line?

MR. PAUL: Objection, Your Honor. Calls for a conclusion.

THE COURT: Sustained. Mr. Copeland, if you could focus -- I'm not quite clear when we are talking about this information. If you go back to that issue with Dr. Stacy so it's clear what was said and what we're talking about at that point, please.

Q. (By Mr. Copeland) Now, you made a phone call to his place at work; is that right?

A. Yes.

Q. And do you know what time they open up shop there and answer the phone?

A. I'm not sure but they were there when I called.

Q. And you inquired in a frantic state of mind, did you not, wanting to know if anybody knew of Marty Phillips doing drugs;

THE COURT: And what would you have asked her?

THE WITNESS: I would have asked her if she knew if there was any chance that she knew if Marty took any drugs.

THE COURT: Okay.

THE WITNESS: Or if anybody up there knew.

THE COURT: All right. And so she gave you a supervisor?

THE WITNESS: Yes. Or well, she gave me some man. don't know.

THE COURT: Some man.

THE WITNESS: Yes.

THE COURT: Did he identify himself?

THE WITNESS: I don't recall if he did.

THE COURT: All right. And so you said what to him, sir?

THE WITNESS: I asked him if he knew of any drugs that Marty might have taken. And he said he didn't know of any but he would run out in the shop and he would check and get right back with me. And he was gone a little while and he come back and he told me in these words that he -- he may have taken or he may have snorted some crack. That was exactly what he said, he may have snorted some crack.

THE COURT: And the question you asked him was whether he had taken any drugs?

THE WITNESS: Yes, the question I asked that man if he

1 knew if he had taken any.

2 THE COURT: All right. And that's what he came back

3 and told you?

4 THE WITNESS: That's what he came back and told me.

5 THE COURT: All right. Go ahead, Mr. Copeland.

6 Q. (By Mr. Copeland) Now, Fred, did he give you any time

7 frame, reference time, point in time as to when he might have

8 snorted some --

9 A. No, he didn't.

10 Q. Now, I guess you gave that information .

11 A. To the doctor.

12 Q. Okay. Now, how did you tell this particular information

13 to Dr. Stacy?

14 A. I think I just walked up to him in the hail.

15 Q. Did you tell him I definitely learned that my son did or

16 did you tell him that he might have?

17 A. I told him exactly what the man told me that he might have

18 snorted some crack. That's exactly what I told the doctor.

19 Q. Now, there came a point in time whenever you got off the

20 phone, you went back and you were with Dr. Stacy and your son

21 was there; right?

22 A. Yeah.

23 Q. Things started getting a little more intense; did they

24 not?

25 A. Yeah, especially after the echocardiogram. During the

echocardiogram -- well, let me back up a little bit before that. Before they did the echocardiogram he was having problems with his oxygen level dropping and they went and took the little thing out of his nose that they put up there and they put a mask on him, but he was so uncomfortable and tossing around he couldn't keep the mask on and his oxygen level started dropping, so they kept put that back up in there. And they kept trying to keep oxygen to him. Then they did the echocardiogram and he got real distressed during that, and his oxygen level was dropping all of the time. And by the time they finished that, the echocardiogram, it was shortly, real shortly after when they took him to the other room to try to put an oxygen tube in or a air tube because his oxygen was dropping, he couldn't get any air anymore. The last thing he said to the doctor, "help me, help me," and they took him.

Q. You okay, Fred?

A. Not really.

Q. Can you go on or do you need a break?

A. Okay. Go ahead.

Q. Fred, were you present when Marty told Dr. Murta that he had been in another hospital with similar symptoms a week earlier?

A. I don't think so. I don't recall him telling him.

Q. Fred, you put this case in the hands of the ladies and gentlemen of the jury and you brought this action on behalf of

A. Yes, there are things on it that concern me very greatly as a doctor.

Q. And what are those Doctor?

A. I think that some of the things that concern me are the fact that in both the history of present illness and on the physical exam and on the plan -- I'm sorry, impression and plan, there is the complaint of chest pain since yesterday, hurting to breathe in and out. During the physical exam there is nothing, there is nothing on the chart that specifically relates to whether or not this patient -- thank you very much -- whether, on the physical exam there's nothing on lungs, there's nothing mentioned on chest to determine whether or not the patient's chest was actually examined, that is if the patient had chest pain, was there any specific point on the chest that was tender, that was painful, was there. If there was going to be pleuritic type chest pain then a reason for that pleuritic type chest pain had to be sought out and determined. Since there are many things that cause pleuritic type chest pain that can be potentially dangerous and life threatening to the patient, and those were never investigated or commented upon.

Q. And, Doctor, I'm sorry, could I stop you right there? Can you please tell us what pleuritic type chest pain is, or pleuritic chest pain?

A. Yes. Pleuritic type chest pain is chest pain that

typically hurts more either with breathing in or breathing out, that is as you breathe or as you take a deep breath the pain varies, implying that it in someway involves the chest wall, the lining, or the lining around the lungs inside the chest, or possibly the lining around the heart, because all of those areas, when involved with a disease process or when involved with some kind of condition, can give you pain that varies when you breath in and out. In other words, breathing in and out actually changes the position and causes different structures in the chest and in the chest wall to move, to change, to rub against each other. So if there's a disease process of those areas then when you breath in and out your pain will vary. Needless to say, pleuritic type chest pain is what the patient had but there is nothing in the physical exam to show that that pleuritic chest pain may have been related to a specific point in tenderness, point of tenderness on the chest wall

In addition, there are other disturbing aspects to both the history and the physical. Specifically on the physical exam, the patient has a pulse of a 112 which is rapid. And at that pulse rate the patient has a blood pressure of a 129 over 55. Now, what's quite disturbing is that when patients have rapid heart rates, their pulse pressure, the pulse pressure being the amount of pressure between the lower number of the blood pressure and the higher number, the difference between 55 and 129, if anything the pulse pressure

tends to narrow, it gets smaller, not always but it can do that. If nothing else it tends to stay normal. This patient had a very wide pulse pressure. It's not normal to have a blood pressure of a 129 over 55. That 55 is very low and is an abnormal finding and needs to be explained. It is not explained anywhere on either further physical exam, on impression or under the patient's treatment plan, so it is never addressed. This is a red flag, if you will allow me to use that analogy. It's a bell or a whistle that should have gone off saying that there's something wrong with this patient and there's something wrong with the patient that needs to be investigated further. And a patient with pleuritic chest pain and this physical finding may have a variety of conditions, some of which could be potentially, rapidly lethal or extremely injury causing and therefore needed to be investigated further.

Q. And, Doctor, if I could stop you right there. How do you investigate that?

A. Well, it's actually not all that hard in an emergency room to further investigate these kinds of findings. The doctor should have ordered an EKG which takes all of a couple of minutes, a chest X-ray, which also takes all of a couple of minutes and drawn some blood to send off blood testing, which again also takes no more than a couple of minutes. And by having done blood testing, a chest X-ray and an EKG in this particular patient, abnormalities would have been found which

would have then caused this patient to have been admitted to the hospital and treated for the condition that he actually had at that particular point in time.

Q. Doctor, do you see anything on Dr. Cobb's note there that indicates that his pulse rate was less than a 112?

A. No, there is no indication anywhere in this typewritten note that at any time in the emergency room was his pulse rate less than 112.

Q. Now, Doctor, in your practice when -- or scratch that. I take it up in New York you -all have triage nurses, also?

A. We all do.

Q. Okay. And do they typically check the patient's pulse in triage?

A. Yes, they do.

Q. If you as a doctor recheck the pulse rate and it changes, what do you do?

A.I document it in the chart. In other words, a change in the pulse rate is a significant physical finding, whether it be good or bad and needs to be documented in the chart. I think that just makes common sense.

Q. Is there anything else inside the Dr. Cobb's note that causes you a problem either on Page 1 or Page 2?

A. Well, if we can word that differently in terms of causing me a problem.

Q. Okay.

problems. That is, again, pleuritic type chest pain, it's not enough to just list it in the impression, it actually needs to be investigated and looked into.

In addition, in terms of the plan, giving him those specific medications and referring back to the discharge sheet, I don't see anything in this note that tells the patient what he may or may not have had, whether or not he should actually-- whether or not -- what he should actually return to the emergency room for, what things he should look out for, what precautions need to be taken and what the effects of the medications both given to him in the emergency room and given to him on discharge might actually be. Now, those aren't in this note at all, but also when you look at the discharge sheet, the discharge sheet itself is incomplete in terms of listing those sorts of things for the patient.

Q. Doctor, what is, I believe -- well, it doesn't list it there that I can see, but there's a drug called Norflex?

A. Yes.

Q. What's Norflex?

A. Norflex is a medication that's used by some physicians as a muscle relaxant. In actuality the mechanism of action of Norflex is not really clearly known. It's my opinion, and I believe most physicians' opinions, that Norflex works mainly through its analgesic or very mild sedative or possibly even pain relieving effects to help with muscular spasm. That is,

reasons.
Q. Do you have an opinion as to whether Mr. Phillips should have been prescribed antibiotics or not?
A. Yes, I do.
Q. What's your opinion?.
A. My opinion is that had this patient received good and accepted medical care in the emergency room he would have had further diagnostic testing and would have been admitted to the hospital and upon admission to the hospital he would have received, as part of good and acceptable medical care, high dose intravenous antibiotics to treated an underlying severe infection. And so I believe the patient should have received antibiotics at that time or very shortly after that time in the emergency room, and would have if he had received good medical care.
Q. Well, Doctor, how do we know if Martin Phillips had received antibiotics on September 23 when he saw Dr. Cobb that he would have lived?
A. Well, we know that when patients have endocarditis or when patients have an infection in their bloodstream, that the earlier and sooner that they receive intravenous antibiotics the more likely they are to survive. I mean, I think that just makes common sense. If you have an overwhelming infection, the earlier you get treatment for it the more you are likely to survive that infection. So that's standard care, that's well

known in the practice of medicine.

Q. Do you have an opinion as to whether Mr. Phillips would be here had he received antibiotics?

A. Yes, I do.

Q. What's your opinion?

A. My opinion is that within a reasonable degree of medical certainty, Mr. Phillips would have survived this very dangerous and very bad infection and would have been here today. It's possible he would have required -- it's not only possible it's extremely likely he would have required a prolonged course of antibiotic therapy, there's a small possibility that he might have even required some kind of valve surgery at some point, not necessarily during that are hospitalization but down the road, but that he would have survived his infection had he been treated properly and would be here today with a long life expectancy afterwards.

MR. TOON: Your Honor, may I approach to grab --

THE COURT: Go ahead.

MR. TOON: Thank you.

Q. (By Mr. Toon) Doctor, does sometimes, I mean, when you are explaining to a person like me that's not a doctor, does it help to sometimes draw a picture and show us what the heck's going on?

A. I think it helps many times even when I'm explaining to other doctors to draw a picture.

hospital; do they, sir?
A. With just those two findings and nothing else, no, they do not.
Q. And in fact a 112 pulse is just — we could characterize that as a little tachycardia; could we not? It's a little bit rapid?
A. I don't know if I would characterize it as little bit rapid. I would characterize it as rapid.
Q. All right.
A. If the patient's pulse was 112, to do a direct comparison when he was deathly ill and at Tulsa Regional Medical Center his pulse was a 120, so it was only eight beats more than that. So I'm not sure - let's put it this way, I would not characterize this as little rapid, I would simply characterize it as what it is, tachycardia, and then be sure that I knew what caused it if I was caring for him, or I were to be caring for him as would be part of the accepted standard of care.
Q. Doctor, you just represented to this jury that the patient's pulse at TRMC was 120. Would you go to the emergency department treatment record when the patient came in and tell us what the pulse was?
A. His pulse is different at different times.
Q. Was it 131, sir?
A. At which point in time are you referring to?
Q. I just referenced you to the emergency department

Q. What do you presently do?

A. I'm director of medical records at Hillcrest Medical Center.

Q. And how long have you been doing that?

A. A year and-a-half.

Q. And how many employees do you supervise there?

A.38 employees.

Q.And in that function as the medical records -- can I call you the medical records custodian --

A.You can.

Q.-- department, basically is what you do there?

A. Yes.

Q.You do track and keep a record for all of the patients who come through Hillcrest Medical Center; is that right?

A.Yes.

Q. Okay. On that particular file, ma'am, that you have, is that the original copy of Martin Shane Phillips' file?

A. Yes, it is.

MR. COPELAND: May I approach, Your Honor?

THE COURT: Yes, go ahead.

MR. COPELAND: May I observe and look at this one?

Q. (By Mr. Copeland) Now, first of all, is it Miss Hagemann or Mrs. Hagemann?

A. Miss.

Q. We have met and had a deposition before; is that right?

of a saw or heard approach to the fact witnesses. She's got I mean, you want to speculate. You can speculate the Mets might win the World Series some day. But so what? All right. Let's move along to something she saw and heard. All right. We 'ye done the dots

MR. COPELAND: Okay.

THE COURT: All right.

MR. COPELAND: All right. One more thing.

THE COURT: All right. Let's go.

(Whereupon counsel returned to their respective places and the following proceedings were had within the presence and hearing of the jury.)

THE COURT: All right. Mr. Copeland, please proceed, sir.

Q. (By Mr. Copeland) Ms. Hagemann, there was a purchase at the time of Martin Shane's death of Tulsa Regional Medical Center by Hillcrest Medical Center, was there not?

MR. PAUL: Objection, Your Honor. No foundation.

THE COURT: Sustained.

Q. (By Mr. Copeland) Ma'am, do you know or are you aware of the purchase of Tulsa Regional Medical Center by Hillcrest Medical Center?

MR. PAUL: Objection. No foundation.

THE COURT: Sustained. She's the head of records, not acquisitions.

Q. By Mr. Copeland) Ma'am, isn't it true that you were working at both the medical records department of Tulsa Regional Center and the medical records department at Hillcrest Medical Center at the time of these events of this lawsuit?

A. No, I'm not. Not at the time -- well, I guess I need to clarify. At the time of -- right now, yes. Today's date, yes, I am.

Q. And, Ma'am, you were also working there at the time of your deposition, weren't you?

A. I'm sorry, could you tell me the date of my deposition so I can tell.

Q. May 1999.

A. Yes, I was.

Q. Okay. And you didn't tell me that, did you?

A. No, sir, you didn't ask.

MR. COPELAND: Counsel I direct your attention to Page 6, line 21.

Q. (By Mr. Copeland) "Question: Where do you presently work?

"Answer: Hillcrest Medical Center" Then that carries over to page 8, line 7 and haven't -- let's see here.

"And haven't worked in any other capacity at Hillcrest; is that correct?"

"Answer: That is correct."

Ma'am, isn't that a little inconsistent with the

duly sworn, testified as follows:

THE COURT: All right. Mr. Toon, please proceed, sir.

MR. TOON: Thank you, sir.

DIRECT EXAMINATION

MR. TOON:

Q. Would you state your name for the record, and if you could, spell your last name for the benefit of the court reporter?

A. Steven Landgarten, L-A-N-D-G-A-R-T-E-N.

Q. And it's Dr. Landgarten?

A. Yes.

Q. Dr. Landgarten, where are you employed?

A. Hillcrest Medical Center.

Q. Okay. And what do you do there, sir?

A. I'm the medical director.

Q. Okay. And the medical director, what are your job duties?

A. Principally it's the relationship between the voluntary medical staff and the administration. I'm responsible for the credentialing of physicians coming on to the staff. As you're aware, the medical staff is voluntary. Physicians may choose to work at a hospital or not, and the board of trustees has to grant them privileges to work there. The core of my job is the evaluation of the qualifications of physicians based on their training and experience to work at the hospital and to review their work periodically to see that they meet the standards of

1 feel there's anything unusual about it, I might not trigger
2 such a review. In this specific case which I assume you are
3 coming to, when I was notified of Mr. Phillips' death I did
4 indeed ask that the department chairman take a look at that
5 emergency room chart to be sure that everything looked okay.
6 Q. Okay. And since you got to that, Doctor, the person that
7 you asked to do the review is named who?
8 A. Dr. Wes Wilson.
9 Q. And I take it then that Dr. Wes Wilson does not have any
10 affiliation with Dr. Carolyn Cobb?
11 A. I believe you take it incorrectly. I believe he does have
12 an affiliation.
13 Q. He does. In fact, sir, isn't Dr. Wilson, the person that
14 you asked to do the review, the president of Tulsa Emergency
15 Physicians, Incorporated?
16 A. I believe he was at that time, yes.
17 Q. And so in other words, you asked the president of the
18 company that Dr. Cobb works for to do the review for you?
19 A. I asked for the chairman of the department of emergency
20 medicine at Hillcrest Medical Center to do the review for me as
21 is called for in the bylaws of the medical staff at Hillcrest
22 Medical Center. coincidentally, Dr. Wilson is also the
23 president of that corporation.
24 Q. Well, did you ever consider that Dr. Wilson could be
25 biased about reviewing what Dr. Cobb did or didn't do?

Q. Well, how close to September 23 of 1998 did you find out?

MR. PAUL: Objection, Your Honor, argumentative. He didn't die until September 28 and it's argumentative. He said he didn't know.

THE COURT: All right. He can ask if he can clarify some appropriate time frame.

Q. (By Mr. Toon) Did you know approximately, sir, in relation --

A. I don't --

Q. Excuse me.-- in relation to his death how soon you found out Marty Phillips had died?

A. I don't recall exactly I believe it was probably within a week after his death.

Q. And how did you find out?

A. Elizabeth Ross called me and notified of me of that.

Q. And Liz Ross is in charge of what, risk?

A. Risk management.

Q. Yeah and the purpose of risk management to limit liability the for the hospital; correct?

A. The purpose of risk management is a number of things. Number one, the safety of everyone in our organization, number two our legal relationships, and number three, where possible, prospectively reduce any liability, identifying those areas where we can improve so that people aren't put at risk and we don't wind up in courtrooms.

A. It was an 11 hour college class.

Q. And as an EMT you went out and did what?

A. Third rode on ambulances and treated people through the fire department, took people to the hospital.

Q. Do you see a lot of sick people?

A. Oh, yeah.

Q. Now, the parties, all of the parties in this case have stipulated that Martin Shane Phillips died on September 28th, 1998. Did you know Martin Shane Phillips?

A. Yes.

And how long did you know him?

Since about the second or third grade.

And what kind of relationship did you have in your earlier years?

A. Well, we were real good friends. Every day after school if I wasn't at his house he was in mine.

Q. And did that kind of socialization -- socializing between the two of you continue on through your later years?

Up until I graduated from high school and got married, and then we pretty much lost each other.

Q. Okay. And then did you have an occasion to see him again at American Crating as an employee?

Yeah, when he started working for us.

Q. And then what was the schematic of your relationship at that time?

A. Just pretty much strictly work

Q. Were you his supervisor or boss or anything like that?

A. Yes.

Q. Now, tracking back to September 28, 1998, did you have an occasion to see Martin Shane Phillips in any, what you would consider apparent -- apparently ill condition prior to or recent in time to his date of death?

A. Yes.

Q. And when do you basically first recall or last recall seeing him close in time to his death?

A. It was either the Tuesday or Wednesday before he passed away, and then again on the Friday before he passed away

Q. So Tuesday and Wednesday and Friday?

A. Tuesday or Wednesday.

Q. Tuesday or Wednesday.

A. And then Friday.

Q. And are you certain that you saw him on Tuesday and Wednesday -- or Wednesday?

A. I saw him on one of the two days.

Q. I'm sorry?

A. One of the two days.

Q. Okay. Now what was the situation when you saw him either on Tuesday or Wednesday?

A. He came up to work to visit with the secretary about trying to get an insurance card. That he had lost his or.

Q. Now, what happened when you saw him on Friday?

A. Well, I had to verbally reprimand him for leaving a bunch of tools out on a jobsite. He left early and left all of his tools out on a jobsite.

Q. Okay. Let me direct your attention over to the monitor to your right.

MR. COPELAND:And, counsel, that will be Plaintiffs' Exhibit 1 9 It has been previously introduced into evidence.

Q. (By Mr. Copeland)Can you see the -- on that monitor there can you see --

A. It's not legible.

Q. Okay.

MR. COPELAND: Your Honor, may I approach?

THE COURT: Go ahead.

Q. (By MR. COPELAND) I direct your attention to --

MR. COPELAND: Your Honor, may I stand here to Retrieve.

THE COURT: Go ahead.

Q. (By Mr. Copeland) I direct your attention to the date there, September 21, 1998. Is that what you are referencing to, you just testified he left early?

A. The 21st?

Q. Yes, sir. Yes.

A. No, that shows he came in late.

Q. Came in late. Does it show that he clocked out?

Q. (Mr. Copeland) What do you mean by the fact that "wrote out time" is not present on that 9/21?

A. That means that he didn't write out his time when he came back from a jobsite, so probably he didn't come back from a jobsite

Q. And by that, to your understanding does that mean he might have left early for the day without clocking out?

MR. PAUL: Objection, Your Honor. Calls for speculation.

THE COURT: Sustained.

Q. (By Mr. Copeland) Now, getting back to, you said he left some tools out and you were going to chew on him a little bit?

A. Yes.

Q. What kind of tools did he leave out?

A. A generator, an air compressor, saws.

Q. Are those --

A. His jobsite tools.

Q. Are those expensive tools?

A. Oh, yeah, probably, five or six or $7,000 dollars worth.

Q. Would that be an uncommon occurrence for Martin to do?

A. Oh, yeah.

Q. Now, when you saw him either on Tuesday or Wednesday, what his appearance that you recall to the best of your memory?

A. It was bad. Very bad.

Q. Did you -- can you give a little more explanation or

expound a little bit for the jury?

A.Oh, he was real pale, sweaty. Just looked like a zombie, like walking dead, like he couldn't hardly move around.

Q.Now, what happened on Friday? Did you see him on Friday at what time?

A.It was, I believe, a little before noon and he came to pick up his check.

Q.Okay. Do you know how he had got to the place of business of American Crating?

A. I believe he drove.

Q. Okay. Do you have personal knowledge of that or you just believe that?

A. I believe he did. I have no personal knowledge.

Q. Now, what did he look like on Friday?

A. Still real bad.

Q. Still real bad. What kind of employee was Martin Shane Phillips?

A. One of the best ones we've ever had. Real dependable, reliable.

Q. Now, in looking at some of these time sheets it says left early -- or came in late, left early. What do you mean, how do you classify an employee as being a good employee for leaving early -- or coming in late and leaving early?

A. Work performance, reliability.

Q. Now, and do you have other employees that also do the same

that issue as well.

THE COURT: Okay. And the express testimony to the contrary by Mr. Lulka who was in fact present versus a hearsay rendition?

MR. TOON: Well, we didn't believe it was hearsay, Your Honor, if you will recall from our prior meetings but I understand that's the Court's ruling.

THE COURT: All right. Let's hear on Dr. Zola briefly. How long will it take, sir?

MR. TOON: I've got it pretty -- well, ten minutes or less. All right. Why don't we hear on the Dr. Zola, just make a complete record in that regard

You might remind Dr. Zola for his next appearance, they don't have a class rank at Harvard. He can't be at the top of his class, there is no such objective measurement there. But he can use that however he sees fit. Go ahead.

MR. TOON: Your Honor, our offer of proof in regards to Dr. Zola is we believe that we have been prejudiced by the Court in relation to not providing testimony from Dr. Zola that the cause of Mr. Phillips bacterial endocarditis or his septicemia being related -- not related to drug use. The Court is going to be allowing testimony in regarding drug use which is why we addressed it in our case-in-chief. And the medical evidence within a reasonable degree of medical certainty from Dr. Zola is that drug use did not only not cause the

septicemia, but in addition did not cause his bacterial endocarditis in a variety of particulars.

Number one is, is the location of the vegetations which were on the aortic valve indicate, according to the literature, that it most likely was not caused by drug use. The reason for that, Your Honor, is is that when the blood comes in initially through the heart and it's pumped out to the lungs, then it comes back to the heart and it goes out to the rest of the body with all of the oxygen in it, therefore, it's typically when the person injects themselves with drugs, you will typically get it on the right side of the heart versus the left side. Because we believe the defendants are going to try to get up and shower the jury with drug evidence, the jury in their own mind is already going to be convinced that the cause of his bacterial endocarditis is drug use.

Additionally, there is medical evidence out there that one of the causes of bacterial endocarditis is bad hygiene. There is a medical record that Mr. Paul's office provided to us that indicates that he had bleeding gums. I don't remember what the date was, but it's undisputed he had bad hygiene. Bad hygiene is a known cause of bacterial endocarditis. And we didn't get into that and Mr. Holeman even objected during this trial not even being able to get up near the door so that we could show the jury that this drug evidence is nothing more than a red herring.

factor and you combine that also, there's the issue of the hygiene. And, Your Honor, I just don't think that we can -- it's something that can't even really be cured at this point, unfortunately, but that is our offer of proof and that's what Dr. Zola would have testified. And that's what the medical literature would show also.

THE COURT: All right. As we've talked about over the course of ten pretrials -- are you done, sir?

MR. TQON: Yes, sir.

THE COURT: Okay. You can have a seat.

MR. TOON: Thank you.

THE COURT: As we talked about over the course of ten trials the reason not to get into is because nobody is to get into the cause of the bacterial endocarditis, and the sole relevance of the drug use was testified most eloquently by Mr. Phillips himself yesterday when he made it clear that this was a matter of high concern because it had to do with how they would diagnose and treat his son. And certainly to have that indicator, at least for purposes of arguing, if they so choose to argue, that it was contributory negligence not to bring it to their attention, that is clearly probative. You heard Mr. Phillips so state from the stand. And that was exactly the issue, for no other reason. I can assure you if they start even for a moment suggesting that the cause of death was drug use, then there will be serious old testament stuff. Okay?

charge. I was given to a lady who told me she was in charge. I again asked her how something like this could happen. I wanted to know how it could happen. She told me that they would find out what had happened and that they would return my phone call.

Q. And did you ever become satisfied with the responses you got from Hillcrest?

A. No.

Q. So what did you decide to do, anything?

A. I wanted medical records and I was told to come down. I went down to get medical records and my name was not on next of kin when they opened the folder. A lady brought it out and opened it and I looked to see who was next of kin and on the form right below next of kin it said no insurance. And that kind of rung a bell with me because he worked with my husband and I knew he had insurance. My husband had sent his card with him on the date he went to the hospital because the married people with children got their cards first, and he needed a number for them to be able to call to verify that he had insurance.

Q. So what did you do whenever you made this realization that this record reflects there was no insurance. Did you decide to do something then?

A. Then I decided to call you as my attorney.

MR. COPELAND: Your Honor, may I approach?

THE COURT: Yes. Go ahead.

MR. COPELAND: Thank you.

Q. (By Mr. Copeland) Now, Christina, can you identify that document or does that look familiar?

A. Yes.

Q. Now, is that the document you were looking at at the time you were at Hillcrest attempting to get the medical records?

A. Yes.

Q. Now, where is it that you say that you saw the words no insurance?

A. Right below this here, right in here, it was right below the name.

Q. And would it be somewhere in this area where it said insurance?

A. Yes.

Q. And you realize that there's nothing here where it says insurance on this document?

A. Yes.

Q. Now, what did it look like was it handwritten or typed?

A. It was -- it was handwritten. I mean, it was -- it was in cursive.

Q. And how big would you say the letters were?

A. Medium, a woman's handwriting.

Q. Now, did you attempt to get the medical records again after you had come to your lawyer's office?

1 communication, the place, day and time of each such
2 communication, the substance of each communication."
3 Now, the identity of the person; did you know the
4 identity of the person whom you dealt with at Hillcrest?
5 A. No.
6 Q. So you couldn't have put that in here; is that right?
7 A. Yes.
8 Q. Okay. And as to the place, date and time, you stated the
9 date, "Approximately mid October 1998, Ms. Daczewitz phoned
10 Hillcrest to find out what she needed to do get take a copy of
11 Martin Shane Phillips record. She was told to come down and
12 sign for them." That's the date; isn't it?
13 A. Yes.
14 Q. Mid October, best you knew?
15 A. Yes.
16 Q. Then also in mid October you attempted to obtain in person
17 the records -- well, that's a different hospital, but as to
18 Hillcrest. The substance of each communication. There's three
19 parts of this; right? You've got the identity of the person
20 which you did not know, you have got the date, place and time
21 which you have stated and the substance of each
communication.
22 Was what you saw "no insurance," a letter written to you?
23 A. No.
24 Q. So it wasn't a written communication in your mind; was it?
25 A. No.

to take a breath?

A. When he tried to take a deep breath he said it really hurt.

Q. And when you hit a bump or when he moved?

A. Yeah, when he moved. Any movement would cause it --

Q. Cause it to hurt again?

A. And he would clench.

Q. Okay.

MR. PAUL: Your Honor, may I look at my notes just a minute?

THE COURT: Yes, go ahead.

MR. PAUL: Sorry. That's all I have. Thank you.

THE COURT: All right.

MR. BEGIN: Briefly, Judge.

THE COURT: All right, Mr. Begin.

CROSS-EXAMINATION

(BY MR. BEGIN:)

Q. You testified earlier or actually Mr. Copeland asked you a question that he had not spoken with you prior to your testimony today; do you recall that question?

A. I don't recall that.

Q. Okay. You have met with Mr. Copeland and Mr. Toon; is that correct?

A. Mr. Copeland, yeah, I've met with them before.

Q. They came up to visit you in Vinita; is that correct?

understanding that the law requires that when patients come into the emergency room to request treatment, that they be given an appropriate medical screening. The courts have been very clear that what that means is that the medical screening process be applied uniformly to all patients who request treatment. It is not a subject, the medical screening, to inquire whether or not the medical screening was done appropriately, whether it was done correctly, just whether it applied to that particular plaintiff the same as it does to all plaintiffs. And I think the evidence in this case -- or all potential plaintiffs. I think the evidence in this case is very clear that Mr. Phillips was given the medical screening. He was seen by the triage nurse, he was then seen by a physician. The evidence is without dispute that that's the way it's done with all of the patients there. If the plaintiffs have some complaint about the diagnosis that was reached, that does not support a claim and a violation of EMTALA.

That in a nutshell, I believe, is our argument. I know that the plaintiffs were claiming something about the fact of this insurance card, but I think Mr. Lulka resolved any misunderstandings that the plaintiffs may have had on that subject because he was very clear in his testimony that they merely asked for the insurance card and they went on and got the rest of the information. There was no indication there that he would not be seen because he didn't have his insurance

Honor, and they ask do you have insurance, and this person does not have insurance that they strongly encourage individuals to go somewhere else if they are in a triage Category III. So the mere fact, Your Honor, that if they -- there's a question of fact here. If intentionally Hillcrest Medical Center --

THE COURT: There's only a question of fact if you have got a fact to controvert Mr. Lulka's testimony.

MR. COPELAND: The fact, Your Honor, is they have a philosophy to strongly encqurage. That's a question of fact.

THE COURT: Okay. All right.

MR. COPELAND: They did not re-test his vitals, Your Honor.

THE COURT: I understand that. And in the conversation that occurred in Mr. Paul's examination of Dr. Zola, they talked about whether or not the testing of Dr. Cobb would be re-testing his vitals. He found perhaps that that was an inadequate re—testing of his vitals, his view, and that's certainly for the jury to determine. But as to whether or not he got an opportunity, an undertaking to examine those issues, that undertaking was made and he so conceded.

MR. COPELAND: And, Your Honor, he's making a legal conclusion as a doctor on that question by Mr. Paul. It's the jury --

THE COURT: No, the legal conclusion was when you were asking about EMTALA.

THE COURT: Does this mean you won't be seconding Mr. Paul's nomination of Mr. Lulka as witness of the year?

MR. BEGIN: Well, I don't know about witness of the year, but he had some helpful things to say.

THE COURT: Well, the fact that he thought he looked very ill and was sweating was not in the helpful category, at least for purposes of your motion right now.

MR. BEGIN: I agree. But he also further admitted that those symptoms were not present for the full period of time that they waited in the reception area.

THE COURT: All right. Anything further on this?

MR. BEGIN: Not on the negligence. We're also moving pursuant to Rule 50 to dismiss the plaintiffs' claim for punitive damages. We have submitted a bench brief or a written motion for the Court's convenience.

Basically the argument is that whether or not punitive damages go to a jury is a question of law. The Oklahoma Statute in that regard sets the standard that the plaintiffs must prove, not by a preponderance of the evidence but by clear and convincing evidence, which is a much higher standard, that there was a reckless disregard for the rights of another. That has been defined by the case law which we've cited in our brief as requiring conduct that supports an inference of malice or evil intent or a conscious disregard for the rights of another and the consequences of actions and it requires an awareness

A. That appears to be the aortic valve in his drawing, yes, sir.

Q. Yes. And you say that's something that you know in retrospect?

A. Yes, from the echocardiogram that was done at the second hospital visit.

Q. And in retrospect, Dr. Bernauer, is that something -- could there have been some of that vegetation present all the way back when Dr. Cobb saw the patient at Hillcrest, in your opinion?

A. Yes, I think there probably was some.

Q. There was?

A. Yes.

Q. Okay. Well, then that raises the question, should Dr. Cobb have been able to discover it on the date when the patient was at Hillcrest with those symptoms.

A. I think that depends on whether you can demonstrate any symptoms from that -- from those particular vegetations. And endocarditis is something that starts with an infection of bacteria on the heart valve and it collects bacteria and fiber and gradually grows into a vegetation.

MR. TOON: Objection, Your Honor. Nonresponsive to the question asked.

THE COURT: Overruled. Go ahead.

Q. (By Mr. Holeman) Go ahead, sir.

that is made worse by motion of the chest wall or respiratory effort.

MR. HOLEMAN: May I approach?

THE COURT: Go ahead.

Q. (By Mr. Holeman) Using this anatomic diagram, Dr. Bernauer, the jury has already heard generally what the anatomy is, but using this anatomic diagram are you able to explain the nature of this pleuritic chest pain?

A. I'll try. The pleura is this thin membrane that lines the inside of the chest cavity. There is also a thin membrane that covers the lung in this case and there's a potential space with a few drops of fluid in the pleural cavity where there is no air or blood or those kinds of things in there. If the lung becomes inflamed or if the chest wall becomes inflamed and you have respiratory motion that causes pain that we call pleuritic pain, that really essentially means pain that arises from the pleura itself.

Q. And does it have any connection with a cardiac problem?

A. No, it does not. The sack that surrounds the heart is the pericardium and it is completely separate from the pleural cavity and they have no communication.

Q. All right. Thank you, Dr. Bernauer. There was testimony yesterday from a gentleman named Lulka who said that the one symptom that was constant with this patient was pain, and there was also testimony that the other symptoms would come and go

dictate two or three in a row after you have seen several patients, you may wait until the end of the day and dictate, you know, all that you haven't dictated earlier, or on occasion you may wait and dictate from notes the next day or even the day after that.

Q. All right, sir. So is it in any way a deviation of the standard of care to dictate the notes within 48 hours?

A. No.

Q. I want to talk to you for a few minutes about differential diagnosis and especially in terms of initial thought processes that you physicians may go through when you first hear about a complaint. Are you with me?

A. Okay.

Q. So a patient comes in to the ER and complains of chest pain. Can you even in a few minutes name all of the things that might be on your initial differential?

A. Probably in a few minutes but it would be lengthy.

Q. Can you just name a few of things that come to mind?

A. Well, you might have -- I break them into categories, like you'd have infectious processes so you could have pneumonia. You have structural processes such as pulmonary emboli, dissecting aneurysm. You have traumatic things. You also think of cardiac problems from, you know, depending on the nature of the chest pain -- and chest pain is so nebulous that you need to begin to hone that down pretty quickly and it will

Doctor. I'm sorry, are you finished?

A. Yes.

Q. Okay. On September 23 of 1998, when he had this infection on his heart valve can you say within a degree of medical certainty whether or not he had an infection in his bloodstream?

A. Well, I don't think that he was septic because he didn't have a fever. I think that he probably was showering bacteria into the bloodstream from time to time.

Q. And showering means -- is that when you have these vegetations or things on your aortic valve, the blood, when it goes by there these little pieces break off, don't they?

A.Yes.

Q. And then they travel through the bloodstream and they infect the body; right?

A. Yes.

Q. And that's what happened jn this case?

A. Yes.

Q. Do you know how many days prior to, when he presented to Dr. Cobb at Hillcrest, Mr. Phillips had this infection on his heart?

A. You mean when it actually started?

Q. Yes, sir. Do you know, I mean, was it a week or a couple of days?

A. I think it's hard to say, but it may have been a few days.

to ask him, if you want to further refine the question you can.

MR. TOON: Sure.

Q. (By Mr. Toon) Doctor, we were -- I was talking about a reasonable degree of medical certainty. What does that mean to you, because I want to make sure that we are on the --

A. Reasonable as to medical certainty is different from legal certainty, as I've come to find out.

Q. Yes, sir, I understand.

A. In the medical community we're talking 75, 80, 90 percent with reasonable medical certainty.

MR. TOON: May I have one moment please, Your Honor?

THE COURT: Yes, go ahead.

MR. TOON: Thank you.

Q. (By Mr. Toon) Doctor, you are familiar with the drug Norflex?

A. Yes.

Q. Do you agree that it is commonly known in the medical community to prescribe Norflex with caution in patients that have tachycardia?

A. That is a cautionary admonition, yes.

Q. And when you're prescribing Norflex to your patients in Oklahoma City, if they have tachycardia you're going to use caution; aren't you?

A. Well, I may. You know, this is a mild tachycardia in a young man who doesn't have any other history of heart symptoms,

by any other evidence in the case or by your personal knowledge.

MR. TOON: I'll just ask --

THE COURT: It's 0 for four.

MR. TOON: Okay. I'll just ask him if he knows what OU Clinic is and if they mention it.

THE COURT: All right.

MR. TOON: Okay.

(Whereupon counsel returned to their respective places and the following proceedings were had within the presence and hearing of the jury

THE COURT: Mr. Toon, please proceed, sir

Q. (By Mr. Toon) Doctor do you know what OU Medical Family Clinic is?

A. Yes, I do.

Q.What is that?

A.That is a clinic that is staffed by residents and faculty with the OU Medical College that's here in Tulsa.

Q.And are there certain types of patients that go there to your knowledge?

A.Yes.

Q. Okay. What types of patients?

A. There are a –

MR. PAUL: Objection, Your Honor. Relevance. It's going one place, Your Honor.

THE COURT: I'll allow it. Go ahead.

MR . PAUL: All right.

A. There are already some patients who are preexisting patients in those clinics so that the residents will see them when they are in the hospital and they will re-refer back to them. It's also available for patients who don't have a personal physician and don't have the means, either private insurance or funds to pay for a private physician's office visit, and so that those clinics are available for those kinds of patients to be referred to. And they are all staffed by well trained faculty that supervises the residents.

Q. (By Mr. Toon) Through the OU School of Medicine?

A. Yes.

MR. TOON: May I approach please, Your Honor?

THE COURT : Go ahead.

MR. TOON: One moment please, Your Honor.

THE COURT: All right.

MR. TOON: I'm having technical difficulty, Your Honor. I apologize.

Q. (By Mr. Toon) Sir, are you aware that in this case Mr. Phillips was referred out to OU Family Practice? OU Family Clinic, excuse me.

A. Yes, after his examination and diagnosis and disposition he was advised to follow-up with the OU Family Practice Clinic which is a common practice in all of the hospitals here in

1A.Yes.

2Q. You were talking to Mr. Paul about vital signs; do you

3 recall that?

4A. Yes.

5 Q. And is it your understanding that the vital signs policy

6 is something that can be followed or is not followed or is

7sometimes followed?

8 A. That policy is written as a guideline. And --

9 Q. Well, Doctor, if I could this is EPP 0099, and this is the

10 vital signs policy. Can you see that on your screen there?

11 A. Yes, I can see that.

12 Q. And it says "Vital signs will be taken and record

13 according to the following procedural guidelines;" is that

14 right?

15 A. Guidelines, yes.

16 Q. Okay. And it doesn't say that they may be, it says will

17be; right?

18A. That's correct.

19 Q. And then down here we have that they will be repeated at

20 least every hour in the emergency department; right? Unless

21it's a minor; correct?

22A. Correct.

23 Q. And then if it is minor you repeat it every two hours; is

24 that right?

25 A. That's correct.

is held to the standard of care. So those are the two instructions. We didn't give a complete and separate instruction as requested by Mr. Holeman but we did refine that standard of care instruction in a way that I believe reflects the law.

And on the verdict form you can see what we've got there and just keep in mind we have some final efforts with respect to the verdict form. We can still do those before we send it back, which means we can have instructions and then final arguments and then if there's still something left over on the verdict form that we want to work out we don't need to send it back because they won't see it or even hear about it until we send it back. All right.

With those instructions, Mr. Toon, first final comments and then we will go to a final record.

MR. TOON: Yes, sir. In regards to the Physician's Wrong Diagnosis that's on Page 30, my objection should be noted for the record regarding including that.

THE COURT: Okay.

MR. TOON: Because we do object to that. And again, I would like renew the objection of including any comparative negligence or contributory negligence instructions in that regard. In regards to the verdict form -- did you want to talk kind of pre-talk?

THE COURT: Yes, go ahead. Please, I mean, this is

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

CRYSTAL STAR PHILLIPS, individually And As next of kin to Martin Shane Phillips, on behalf of THE ESTATE OF MARTIN SHANE PHILLIPS,By and through her mother, legal guardian and nextfriend, MINNIE CHRISTINA, DACZEWITZ and FRED MARTIN PHILLIPS JR.,parent of Martin Shane Phillips the Plaintiffs,	)	FILED MAR 31 2000
vs.	)	Case No.98-CV-829H(E)
HILLCREST MEDICAL CENTER, an Oklahoma corporation doing business in the State of Oklahoma, and CAROLYN COBB, a physician, and TULSA EMERGENCY PHYSICIANS, INC., an Oklahoma Corporation doing business in the State Of Oklahoma the Defendants.	)	

REPORTERS TRANSCRIPT OF PROCEEDINGS

HAD ON NOVEMBER 12, 1999

PRETRIAL CONFERENCE

BEFORE THE HONORABLE SVEN ERIK HOLMES, Judge

questionnaire, the only issue regarding Hillcrest as to drug history -- and Mr. Haskins I'm not sure has reviewed the questionnaire -- but the questionnaire doesn't ask about a total history. Like we talked about last time, Your Honor, if I went to Hillcrest and I smoked pot three years ago, which I'm not admitting on the record I have, but let's say I did three years ago and I go to Hillcrest, if that question was asked of me, Your Honor, or of anybody else in this room, do you use, if we put no, if we put no, we do not use but I have done it three years ago, did I lie on that questionnaire? Did I provide the doctor with false information? Of course not. Of course not. They have never alleged that there was any other question about drug history other than the questionnaire. That's all they have. They have never said we have information. We asked Martin Phillips do you use drugs and he said no. All they have is this thing is checked no. And that's a lot different, Your Honor, than at Tulsa Regional after this plethora of tests are done and they see this white cell count, there is something definitely wrong, and they say, hey, can you find out for us?

Now also, Your Honor, in regards to what Fred Phillips said to the doctor. Fred Phillips after this third person told the second person after the first person told the second person on the phone, he said that he possibly had snorted drugs. Okay. That's what was said to the doctor and that's in the affidavit in which we filed today. That goes back to this

whole deal about history versus present use.

THE COURT: Right. And that was a flawed argument when you made it the last time we were here and it's equally flawed now, this are you having sex with this woman in the middle of this deposition? No. We have been there. Now, we talked about it before. That argument is merely misdirected. Now, I find it to be highly probative and I will admit it.

Now, let's move on to the other issues. We have questions of other evidence of -- that are intended to be put on dealing with drug use. Why don't you address your attention to that?

MR. TOON: May I have one moment please, Your Honor?

THE COURT: Yes, go ahead.

MR. TOON: Your Honor, before we move on if we could please, sir, I want to make sure that I do have a clear understanding regarding, you are allowing in the statement that was made by Mr. Phillips to the doctor?

THE COURT: Right. And it's in the records; right? Isn't it in Tulsa Regional records?

MR. TOON: Yes, it is. And I'm not -- and we don't -- regarding what was placed in there versus what was actually said, we obviously have an issue with that because I don't think the records are accurate in -that regard. But also --

THE COURT: You agree that medical records are not hearsay; right?

MR. TOON: No, I think the medical records are hearsay.

THE COURT: Okay. All right. That will be admitted. Go ahead.

MR. TOON: Yes, sir. Additionally my understanding is that the defendants, even though their own medical experts said that he had bacterial endocarditis on the day he went to Hillcrest, they are not going to stipulate that he had bacterial endocarditis on that day? And I want to -- before we leave that I mean it's kind of like they want it both ways. They want to say, well, if we would have had this information we could have diagnosed bacterial --

THE COURT: I don't know what it is before we leave what? Whatever we left was a ruling by the Court and you have been asked to direct your attention to the other witnesses. Now, why don't we just move to that.

MR. TOON: Yes, sir.

THE COURT: Because you noted that it's critical that we conclude these issues on these motions in limine about their drug testimony.

MR. TOON: Yes, sir.

THE COURT: If you could address yourself to that then I will be able to achieve that thing that you have said is critical. All right.

MR. TOON: Yes, sir. In regards to Melody Brady,

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

CRYSTAL STAR PHILLIPS, individually, And As next of kin to Martin Shane Phillips, on behalf of THE ESTATE OF MARTIN SHANE PHILLIPS, By and through her mother, legal guardian and next friend, MINNIE CHRISTINA DACZEWITZ and FRED MARTIN PHILLIPS JR., parent of Martin Shane Phillips **the Plaintiffs,** **vs.** **HILLCREST MEDICAL CENTER, an Oklahoma corporation doing business in the State of Oklahoma, and CAROLYN COBB, a physician, and TULSA EMERGENCY PHYSICIANS, INC., an Oklahoma Corporation doing business in the State Of Oklahoma** **the Defendants.**	**FILED** **DEC 6 1999** **Phil Lombardi, Clerk** **U.S. DISTRICT COURT** **Case No. 98-CV-829H(E)**

PLAINTIFFS' OBJECTION TO CIVIL MINUTES OF THIS COURT DATED NOVEMBER 23, 1999

COME NOW, Plaintiffs, and hereby provide the following objection to the Civil Minutes of this Court as to the following:

1. The Civil Minutes dated November 23, 1999, state "Parties stip that this is 'contributory negligence' case."

Plaintiffs do not stipulate that this is such a case. Plaintiffs have never stipulated that this is a contributory negligence case.

Respectfully submitted,

By: /s/ Richard S. Toon

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ATTORNEYS FOR PLAINTIFFS

CERTIFICATE OF SERVICE

I, Richard S. Toon, hereby certify that on the 6th day of December, 1999, a true and correct copy of the above and foregoing document was mailed, postage prepaid to:

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